

LET'S TALK ABOUT YOUR 2026 BENEFITS



Harlem CSD 122





BENEFITS OVERVIEW

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Harlem CSD 122 is proud to offer a comprehensive benefits package to eligible, full-time employees as stated in your Collective Bargaining Agreement (CBA). The complete benefits package is briefly summarized in this booklet. For more detailed information, plan booklets, are available online under Harlem’s HR tab.

You share the costs of some benefits (medical and dental), and Harlem CSD 122 provides other benefits at no cost to you (ZERO, on-site clinic, life, accidental death & dismemberment). In addition, there are voluntary benefits with reasonable group rates that you can purchase through payroll deductions.

Benefits Offered

- Medical / Prescription Drug / Dental (Packaged Offering)
- ZERO (Supplemental Health Benefit Included with PPO Plans)
- Harlem Health Clinic (Supplemental Health Benefit included with all medical plans)
- Voluntary Vision
- Flexible Spending Account s(FSA)
- Basic Life and AD&D Insurance
- Voluntary Life and AD&D Insurance
- Employee Assistance Program

Eligibility

You and your dependents are eligible for Harlem CSD 122 benefits as stated in your Collective Bargaining Agreement (CBA).

Eligible dependents are your spouse, civil union partner, children under age 26 (military age 30), and disabled dependents of any age, are Harlem CSD 122’s eligible dependents.

The District medical plans have a “spouse carve-out.” If you are enrolling a spouse for coverage, see Human Resources for policy and affidavit form.

Elections made now will remain until the next open enrollment unless you or your family members experience a qualifying event.

If you experience a qualifying event, you must contact HR within 30 days.

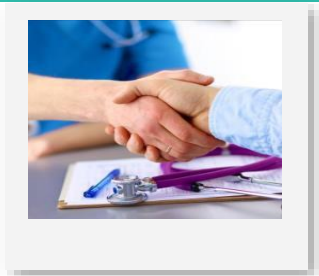
If you have Medicare or will become eligible for Medicare in the next 12 months, a Federal law gives you more choices about your prescription drug coverage. Please see page 25 – 26 for more details.

This document is an outline of the coverage provided under your employer’s benefit plans based on information provided by your company. It does not include all the terms, coverage, exclusions, limitations, and conditions contained in the official Plan Document, applicable insurance policies and contracts (collectively, the “plan documents”). The plan documents themselves must be read for those details. The intent of this document is to provide you with general information about your employer’s benefit plans. It does not necessarily address all the specific issues which may be applicable to you. It should not be construed as, nor is it intended to provide, legal advice. To the extent that any of the information contained in this document is inconsistent with the plan documents, the provisions set forth in the plan documents will govern in all cases. If you wish to review the plan documents or you have questions regarding specific issues or plan provisions, you should contact your Human Resources/Benefits Department.





MEDICAL BENEFITS



Administered by Blue Cross Blue Shield of Illinois

Comprehensive and preventive healthcare coverage is important in protecting you and your family from the financial risks of unexpected illness and injury. A little prevention usually goes a long way— especially in healthcare. Routine exams and regular preventive care provide an inexpensive review of your health. Small problems can potentially develop into large expenses. By identifying the problems early, often they can be treated at little cost.

Comprehensive healthcare also provides peace of mind. In case of an illness or injury, you and your family are covered with an excellent medical plan through Harlem CSD 122.

Harlem CSD 122 offers you a choice of two (2) PPO medical plans and one (1) High Deductible Health Plan (HDHP) that is compliant with a Health Savings Account (H.S.A.). By utilizing in-network provider you may select where you receive your medical services. If you use in-network providers, your costs will be less.

In-Network Benefits	PPO PLANS		HDHP / H.S.A. PLAN
	Plan 1—\$1,000 Deductible	Plan 2—\$1,500 Deductible	Plan 3—H.S.A. Plan
Annual Deductible	\$1,000 per person	\$1,500 per person	\$3,400 single / \$6,000 family
Annual Out-of-Pocket Maximum (includes deductible)	\$3,500 per person / Family Maximum of \$11,300	\$4,000 per person / Family Maximum of \$11,300	\$4,500 single / \$9,000 family
Coinsurance	80%	80%	80%

DOCTOR'S OFFICE

	Plan 1—\$1,000 Deductible	Plan 2—\$1,500 Deductible	HDHP / H.S.A. PLAN
Primary Care Office Visit	\$30 copay	\$30 copay	80% after deductible
Specialist Office Visit	\$35 copay	\$35 copay	80% after deductible
Urgent Care	\$40 copay	\$40 copay	80% after deductible
X-Rays & Labs	\$25 copay	\$25 copay	80% after deductible
Wellness Care (routine exams, x-rays/tests, immunizations, well baby care and mammograms)	100%	100%	100% (Deductible does not apply)

PRESCRIPTION DRUGS—PERFORMANCE SELECT FORMULARY IS EFFECTIVE 1/1/2026

	Plan 1—\$1,000 Deductible	Plan 2—\$1,500 Deductible	HDHP / H.S.A. PLAN
Calendar Year Out-of-Pocket Maximum—Prescription Copays	\$1,000 Single / \$3,000 Family		Included in Medical Plan Deductible
Retail—Generic Drug (30-day supply)	\$10 copay		80% after deductible
Retail—Preferred Brand Name Drug (30-day supply)	25% coinsurance; maximum of \$45		80% after deductible
Retail—Non-Preferred Brand Name Drug (30-day supply)	50% coinsurance; maximum of \$60		80% after deductible
Specialty Medications (Accredo Pharmacy 30-day supply)	\$215 copay		80% after deductible
Mail Order—Generic Drug (90-day supply)	\$0 copay for 2026 Preventive Care Drug List (for certain generic medications) All other generic meds — \$25 copay		\$0 copay for 2026 Preventive Care Drug List (for certain generic medications) All other generic meds — 80% after deductible
Mail Order—Preferred Brand Name Drug (90-day supply)	25% coinsurance; maximum of \$113		80% after deductible
Mail Order—Non-Preferred Brand Name Drug (90-day supply)	50% coinsurance; maximum of \$150		80% after deductible

MEDICAL BENEFITS (Continued)

In-Network Benefits	PPO PLANS		HDHP / H.S.A. PLAN
	Plan 1—\$1,000 Deductible	Plan 2—\$1,500 Deductible	Plan 3—H.S.A. Plan
MENTAL HEALTH SERVICES & SUBSTANCE ABUSE SERVICES			
Inpatient	\$500 copay	\$500 copay	80% after deductible
Office Visit (Psychotherapy)	\$30 copay	\$30 copay	80% after deductible
Outpatient	80% after deductible	80% after deductible	80% after deductible
HOSPITAL SERVICES			
Emergency Room	90% (Deduct Waived) <i>\$350 Copay for Non-Emergent Services</i>	90% (Deduct Waived) <i>\$350 Copay for Non-Emergent Services</i>	80% after deductible
Inpatient Hospital Expenses	\$500 copay	\$500 copay	80% after deductible
Inpatient Facility Fee	80% after deductible	80% after deductible	80% after deductible
Inpatient Physician/Surgery	80% after deductible	80% after deductible	80% after deductible
Outpatient Physician/Surgery	80% after deductible	80% after deductible	80% after deductible
Inpatient & Outpatient Facility—X-ray/Labs	90% after deductible	90% after deductible	80% after deductible
Outpatient Facility Imaging—MRI/CT/PET Scans	80% after deductible	80% after deductible	80% after deductible
Ambulance Service	80% after deductible	80% after deductible	80% after deductible
OTHER SERVICES			
Maternity Office Visit (Applies to First Pre-Natal Visit) (Dependent Maternity Excluded)	\$30 copay	\$30 copay	80% after deductible
Childbirth Delivery/Inpatient Hospital Facility Fee	\$500 copay	\$500 copay	80% after deductible
Childbirth Inpatient Physician/ Surgeon Fees	80% after deductible	80% after deductible	80% after deductible
Chiropractic Services	\$35 copay	\$35 copay	80% after deductible
Speech Therapy	\$30 copay	\$30 copay	80% after deductible
Physical & Occupational Therapy	80% after deductible	80% after deductible	80% after deductible
Home Health Care	80% after deductible	80% after deductible	80% after deductible
Skilled Nursing	80% after deductible	80% after deductible	80% after deductible
Hospice Care	80% after deductible	80% after deductible	80% after deductible
Durable Medical Equipment (DME)	80% after deductible	80% after deductible	80% after deductible
Hearing Aids & Related Expenses	80% after deductible	80% after deductible	80% after deductible

HOW THE PLANS WORK

All three medical plans use the Blue Cross Blue Shield of Illinois PPO network and cover 100% of the cost for preventive care services like annual physicals and routine immunizations. The way you pay for care is different with each plan.

With the **HDHP**, you pay the full negotiated cost for medical services and prescription drugs until you meet your annual deductible. If you meet the deductible, you and the plan share the costs (coinsurance) until you reach the annual out-of-pocket maximum. After that, the plan pays for 100% of your claims for the rest of the year. **Your paycheck deductions for this plan are lower than the PPO plan.**

The **PPO plan** has set copays for some services and a deductible and coinsurance for others. Copays do not apply toward your deductible but do apply to your out-of-pocket maximum. This means you will pay copays until you reach your annual out-of-pocket maximum. **This plan has higher paycheck deductions than the HDHP.**

PAYING FOR HEALTH CARE

Harlem CSD 122 offers several ways to set aside pre-tax dollars to pay for medical, prescription drug, dental and vision care expenses. The health care accounts available to you depend on the medical plan you choose.

	HSA	FSA
What medical plan can I choose?	HDHP	PPO plan
What expenses are eligible?	Medical, prescription, dental & vision care (See IRS publication 502 for a full list)	Medical, prescription, dental & vision care (See IRS publication 502 for a full list)
When can I use the funds?	Funds are available as you contribute to the account	All of the funds you elect for the year are available on January 1
Can I roll over funds each year?	Yes, funds roll over from year-to-year and are yours to keep (even if you change jobs)	There is a \$680 roll over amount to use in the next plan year; You will lose any funds over that amount at the end of the year
How do I pay for eligible expenses?	With your Bank's debit card	With your TASC debit card (You can also submit claims for reimbursement online at www.tasconline.com)
How much can I contribute each year?	You can contribute \$4,400 for individual coverage or \$8,750 for family coverage (this total includes company funding) in 2026	You can contribute \$3,400 for medical FSA or \$5,000 or dependent care FSA in 2026
Can I change my contributions throughout the year?	Yes, you can notify HR to change your Per paycheck HSA contributions at any time	No, unless you have a qualifying life event, you choose an annual FSA election amount during open enrollment and that amount is taken out of each paycheck in equal increments
How do I substantiate expenses per IRS requirements?	You are responsible for keeping records of your H.S.A. eligible itemized receipts and/or EOBs each tax year.	For debit card transactions not automatically substantiated, TASC will request information to substantiate the expense.



About your health center



The care team at Harlem 122 Health Clinic cares about your wellbeing. That’s why we allow you to spend as much time as you need with your provider. With our app and online patient portal, you have 24/7 access to manage your care including messaging your provider, requesting refills, and more. And the best part? Care is available to you at little to no cost!

Harlem 122 Health Clinic

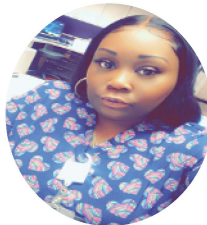
1 Huskie Circle
Machesney Park, IL 61115
779-260-4495

Meet your Team



Mahtab Tashakori, MD

Dr. Mahtab Tashakori graduated from medical school in Iran in 1996. She earned her family practice specialty at University of Illinois in Chicago. From 2009 to 2024, she served as a dedicated family physician at OSF, earning a reputation for her empathetic patient care and personal connections.



Caprisha Williams MA

My name is Caprisha, and I have been in healthcare for over 20 years starting as a CNA in 2003, a Phlebotomist in 2010, then becoming a Certified Medical Assistant in 2016. I have a degree in Healthcare Administration, graduating with honors at the top of my class. I am a business owner, mother of 4 and grandmother of 1. In my free time I enjoy reading, cooking, and spending quality time with my family and our dog Nova.



Cassie Weik, RN

I have been a registered nurse since 2019. My career began in 2013 as a medical assistant, where I gained foundational knowledge and skills that paved the way for my advancement into nursing. I’ve had the privilege of working in various specialized roles, including wound care and pain management, which allowed me to deepen my expertise in patient care.

Hours

- Mon.** 7am - 5pm
- Tues.** 8am - 6pm
- Wed.** 7am - 5pm
- Thur.** 8am - 6pm
- Fri.** 9am - 1pm

Clinic will break for lunch from 12pm-1pm Mon-Thurs



Schedule an appointment
Call 779-260-4495
or visit my.marathon.health





Available to Employees Enrolled in PPO 1000/1500 Medical Plan

Healthcare Simplified To \$0

Providers Partner with ZERO, Reducing Costs

We work directly with providers to get fair pricing on planned care. This allows healthcare providers to enjoy fast, hassle-free payments, and no patient collections.

Employers Benefit, Lower Plan Costs

Because of the reduced costs ZERO receives for services, Harlem School District covers the full cost of the services you need, so you don't have to.

You, as a Member Receive \$0 Care Through ZERO

Because Harlem School District saves with ZERO, you and your dependents on the PPO Plan receive healthcare that is accessible, affordable & \$0.

*If you have a HDHP, you must reach the deductible before you can use the ZERO benefit.

You Always Have a Choice



Best For:	Primary Care
	Specialist Visits
	Emergency



Best For:	Imaging
	Surgical Procedures
	Physical Therapy

Step 01

Connect with your Personal Health Assistant to see if care is covered.

Step 02

ZERO will help you find a provider and send your order over to them.

Step 03

The provider gets you scheduled for the care you need, for \$0. **Yep, ZERO.**



Chat live:
my.zero.health



Give us a shout:
855.816.0001



Drop us a line:
help@zero.health



DENTAL BENEFITS

Administered by Delta Dental Plan of Illinois

Good oral care enhances overall physical health, appearance and mental well-being. Problems with the teeth and gums are common and easily treated health problems. Keep your teeth healthy and your smile bright with the Harlem CSD 122 dental benefit plan.

Delta Dental does not issue ID cards. Your dentist will verify eligibility with DDIL prior to receiving care.

SERVICES	PPO*, PREMIER NETWORKS**/ OUT-OF-NETWORK***
Annual Deductible (per calendar year)	None
Annual Benefit Maximum (per calendar year)	\$2,500
Preventive Dental Services (cleanings, exams, x-rays)	85%
Basic Dental Services (fillings, root canal therapy, oral surgery)	85%
Major Dental Services (crowns, inlays, onlays, bridges, dentures)	50%
Orthodontia Services (Dependent children covered to age 19)	50% to \$1,000 lifetime maximum

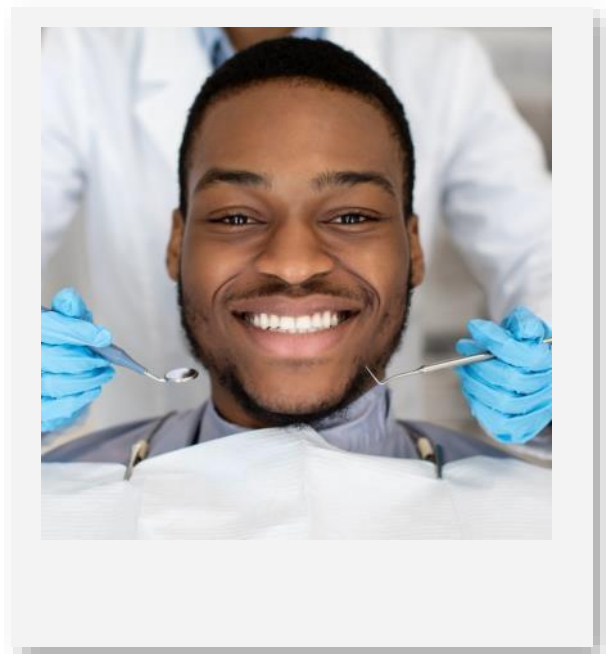
ToGoSM Carryover Feature: Your plan allows you and your covered dependents to carry over qualified unused portions of your annual maximum from one year to the next.

Enhanced Benefits Program: Your plan provides additional cleanings and/or applications of topical fluoride to people with specific health conditions that put them at risk for oral health disease. The costs of the additional cleanings and fluoride treatments will be applied to your annual maximum.

***Delta Dental PPO** dentists accept payment based on the lesser of the submitted fee (their usual fee) or Delta Dental's allowed PPO fee. PPO network dentists cannot charge you for costs exceeding the PPO fee.

****Delta Dental Premier** dentists accept payment based on the lesser of the submitted fee (their usual fee) or Delta Dental's maximum plan allowance. Premier dentists may not charge you for costs exceeding the maximum plan allowance.

*****Out-of-Network** dentists do not agree to Delta Dental's allowed fees as payment in full; payment is based on the lesser of the submitted fee (their usual fee) or Delta Dental's maximum plan allowance. These dentists can charge you for costs exceeding the maximum plan allowance.





VISION BENEFITS



Not everyone's personal situation is the same; your family needs may be different from the needs of your coworkers.

In recognition of these differences, we offer voluntary benefits, which you can purchase at group rates.

VOLUNTARY VISION BENEFITS

Administered by VSP

Regular eye examinations can not only determine your need for corrective eyewear but also may detect general health problems in their earliest stages. Protection for the eyes should be a major concern to everyone.

Your coverage from a VSP Signature Network Provider.

VSP SIGNATURE NETWORK	IN-NETWORK	OUT-OF-NETWORK
Eye Exam — once every 12 months	\$20 copay; covered in full	\$20 copay; up to \$50

LENSES — ONCE EVERY 12 MONTHS

Single Vision Lenses	\$20 copay	\$20 copay; up to \$50
Lined Bifocal Lenses	\$20 copay	\$20 copay; up to \$75
Lined Trifocal Lenses	\$20 copay	\$20 copay; up to \$100
Premium & Custom Progressive Lenses	\$80—160 copay	Up to \$75
Frames — once every 24 months	\$200 Frame Allowance 20% Savings over Allowance	Up to \$70
Walmart/Sam's Club	\$200 Frame Allowance	Up to \$70
Costco	\$110 Frame Allowance	Up to \$70
Elective Contact Lenses — once every 12 months if you elect contacts instead of lenses/frames	\$130 Allowance	Up to \$105
LightCare Benefit	Allows you to use your frame allowance for non- prescription blue light filtering glasses or sunglasses	

No need for an ID card!

To take advantage of your VSP vision benefit, simply contact a VSP Signature Network provider and let them know you have VSP coverage —they handle the paperwork for you.



FLEXIBLE SPENDING ACCOUNTS

FLEXIBLE SPENDING ACCOUNT

Administered by TASC

You can save money on your medical and/or dependent day care expenses with an FSA. You set aside funds each pay period on a pretax basis and use them tax-free for qualified expenses. You pay no federal income or Social Security taxes on your contributions to an FSA. (That's where the savings comes in.) Your FSA contributions are deducted from your paycheck before taxes are withheld, so you save on income taxes and have more disposable income.

2026 Limits

Medical Spending Limit \$3,400

Dependent Care Spending Limit \$5,000

For this Annual Enrollment, your current 2025 FSA election will automatically update for the 2026 plan year to take advantage of the medical and/or dependent care FSA. If you DO NOT want to continue your medical or dependent care FSA OR wish to change the annual contribution amount, you will need to take action in TylerMunis. Otherwise, you will be auto-enrolled for the same contributions or the medical FSA maximum if elected for 2025 calendar year.

For the medical FSA, you may carryover up to \$680 for the next plan year if you have funds remaining at the end of the calendar, and you must re-enroll to have this carryover benefit available to you.

MEDICAL FSA DEBIT CARD SUBSTANTIATION

Recently, the IRS released guidance clarifying that TPAs must take a more active role in substantiating FSA expenses, especially for medical and dental debit card transactions. The IRS states the following for debit card substantiation:

ACCEPTABLE DOCUMENTS

- Bag Tags from prescriptions
- Explanation of Benefits (EOB's)
- Itemized Statements from the provider

FIVE KEY PIECES OF DOCUMENTATION

1. Provider Name – On the receipt
2. Date of Service – Cannot be the paid date
3. Patient Name – On the receipt
4. Service Rendered – Need description of service – cannot be a credit card receipt
5. Total Patient Responsibility

Credit Card receipts are **not** valid forms of documentation. TASC needs to ensure that the service paid for is within the current plan year.

H.S.A. Paired with High Deductible Health Plan (HDHP)

HEALTH SAVINGS ACCOUNTS

For those employees that elect to participate in the High Deductible Health Plan (HDHP) that is compliant with a H.S.A., the District will provide you with an employer H.S.A. annual contribution per your Collective Bargaining Agreement. You can open an H.S.A. bank account and contribute on a pre-tax basis up to the IRS limits.

2026 Limits

Single—\$4,400

Employee + Spouse - \$8,750

Employee + 1 Child - \$8,750

Employee + Children - \$8,750

Family—\$8,750

Catch-up Contribution Over Age 55 & Older—\$1,000

H.S.A. Board Annual Contribution	Support Staff	Certified Staff (Teacher / Admin / At-Will)
Employee	\$1,500	\$1,500
Employee + Spouse	\$2,000	\$2,000
Employee + Child	\$2,000	\$2,000
Employee + Child(ren)	\$2,500	\$2,500
Family	\$2,500	\$2,500

H.S.A. contributions are paid half in January and half in July.

Employees hired after the first business day in January or the first business day in July will receive a one-time contribution equal to twenty-five percent (25%) of the Board required annual contribution upon enrollment in the H.S.A. plan.



District-Provided BASIC LIFE INSURANCE



LIFE AND ACCIDENTAL DEATH & DISMEMBERMENT INSURANCE

Insured by BCBSIL Dearborn

Life Insurance - No Cost to You!

Life insurance provides financial security for the people who depend on you. Your beneficiaries will receive a lump sum payment if you die while employed by Harlem CSD 122. **The District provides basic life insurance** as stated in your Collective Bargaining Agreement (CBA) **at no cost to you.** Some restrictions apply per the CBA.

Accidental Death and Dismemberment (AD&D) Insurance

Accidental Death and Dismemberment (AD&D) insurance provides payment to you or your beneficiaries if you lose a limb or die in an accident. Harlem CSD 122 provides AD&D coverage stated in your Collective Bargaining Agreement (CBA) at no cost to you. Some restrictions apply per the CBA.

Life Insurance Beneficiaries

Don't forget to update your life insurance beneficiary in Frontline Central. It's important to review your beneficiary designations annually. Beneficiaries can be updated at anytime. **Follow these steps to update your beneficiary in Frontline Central - My Forms - Forms I Can Start - OE Beneficiaries.**



VOLUNTARY LIFE INSURANCE

VOLUNTARY LIFE AND AD&D INSURANCE - Additional Option

Insured by BCBSIL Dearborn

Life insurance provides financial security for the people who depend on you. Harlem CSD 122 provides you with an opportunity to purchase additional voluntary life (also known as supplemental life) insurance and accidental death and dismemberment (AD&D) coverage at your own expense through after-tax payroll deductions.

Voluntary Life and AD&D insurance premiums are based on your age and are considered Term Life policies with no cash value. Age-banded rates apply and age reductions apply if over age 65. **The coverage is provided at group term life rates** for you and your spouse and children dependents. **The employee must participate in order to elect coverage for spouse and/or dependents.** This benefit is offered in addition to the Basic Life and AD&D benefit that the District provides at no cost to you.

For the **2026 annual enrollment period**, BCBSIL Dearborn Life Insurance is offering an opportunity for **employees to “buy-up” one increment of \$10,000 for employee and \$5,000 for a spouse.** This applies if you are below the current guarantee issue amount of \$150,000 for employee and \$50,000 for a spouse. Child(ren) are covered up to age 26 at \$10,000.

Note the following:

- Amount limited to the guarantee issue amount based on plan eligibility rules.
- Spouses over age 60 will require Evidence of Insurability (EOI).
- Anyone declined or withdrawn previously are not eligible for coverage.
- Additional paperwork may be required; you will be advised by Human Resources.
- Benefits include conversion, portability, beneficiary resources and a travel assistance program.

For a comprehensive list of exclusions and limitations, please refer to the Certificate of Insurance (available online through the District's human resources portal). The Certificate also provides all requirements necessary to be eligible for coverage and benefits.

Harlem Consolidated School District #122

Eligibility

All eligible, active full time employees

Supplemental Life and AD&D

Employee Benefit: **\$20,000 to \$800,000 in \$10,000 increments.**

Spouse Benefit: **\$10,000 to \$50,000 in \$5,000 increments.
(not to exceed 50% of the employee benefit)**

Note: Spouse may not have coverage unless the employee has coverage.

The spouse benefit may not exceed the employee benefit amount.

Guarantee Issue*

Employee	\$150,000
Spouse	\$50,000

*new hires

Child Coverage

Birth to 15 days:	\$100
15 days to 6 months:	\$250
6 months to age 26:	\$10,000

Life and AD&D benefits reduce by 35% of the original amount at age 65 and further reduce by 60% of the original amount at age 70. 80% of the original amount at age 75.

Supplemental Life and AD&D

Premium Cost (Based on 26 payroll deductions per year)

Employee	
Supplemental Life	
Monthly rates per \$1,000	
Age	Rates
Under 20	\$0.055
20-24	\$0.055
25-29	\$0.069
30-34	\$0.095
35-39	\$0.105
40-44	\$0.135
45-49	\$0.185
50-54	\$0.315
55-59	\$0.595
60-64	\$0.915
65-69	\$1.765
70-74	\$2.865
75+	*

*Please contact your HR Department

Supplemental AD&D	
Monthly rates per \$1,000	
Employee	Rates
Employee	\$0.015

Dependent Life (Children)		
Monthly Premium per Family		
	Life	AD&D
\$10,000	\$2.55	\$0.15

Benefit Amount	EE AD&D	ATTAINED AGE											
		<20	20-24	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70-74
\$20,000	\$0.14	\$0.51	\$0.51	\$0.64	\$0.88	\$0.97	\$1.25	\$1.71	\$2.91	\$5.49	\$8.45	\$16.29	\$26.45
\$30,000	\$0.21	\$0.76	\$0.76	\$0.96	\$1.32	\$1.45	\$1.87	\$2.56	\$4.36	\$8.24	\$12.67	\$24.44	\$39.67
\$40,000	\$0.28	\$1.02	\$1.02	\$1.27	\$1.75	\$1.94	\$2.49	\$3.42	\$5.82	\$10.98	\$16.89	\$32.58	\$52.89
\$50,000	\$0.35	\$1.27	\$1.27	\$1.59	\$2.19	\$2.42	\$3.12	\$4.27	\$7.27	\$13.73	\$21.12	\$40.73	\$66.12
\$60,000	\$0.42	\$1.52	\$1.52	\$1.91	\$2.63	\$2.91	\$3.74	\$5.12	\$8.72	\$16.48	\$25.34	\$48.88	\$79.34
\$70,000	\$0.48	\$1.78	\$1.78	\$2.23	\$3.07	\$3.39	\$4.36	\$5.98	\$10.18	\$19.22	\$29.56	\$57.02	\$92.56
\$80,000	\$0.55	\$2.03	\$2.03	\$2.55	\$3.51	\$3.88	\$4.98	\$6.83	\$11.63	\$21.97	\$33.78	\$65.17	\$105.78
\$90,000	\$0.62	\$2.28	\$2.28	\$2.87	\$3.95	\$4.36	\$5.61	\$7.68	\$13.08	\$24.72	\$38.01	\$73.32	\$119.01
\$100,000	\$0.69	\$2.54	\$2.54	\$3.18	\$4.38	\$4.85	\$6.23	\$8.54	\$14.54	\$27.46	\$42.23	\$81.46	\$132.23
\$110,000	\$0.76	\$2.79	\$2.79	\$3.50	\$4.82	\$5.33	\$6.85	\$9.39	\$15.99	\$30.21	\$46.45	\$89.61	\$145.45
\$120,000	\$0.83	\$3.05	\$3.05	\$3.82	\$5.26	\$5.82	\$7.48	\$10.25	\$17.45	\$32.95	\$50.68	\$97.75	\$158.68
\$130,000	\$0.90	\$3.30	\$3.30	\$4.14	\$5.70	\$6.30	\$8.10	\$11.10	\$18.90	\$35.70	\$54.90	\$105.90	\$171.90
\$140,000	\$0.97	\$3.55	\$3.55	\$4.46	\$6.14	\$6.78	\$8.72	\$11.95	\$20.35	\$38.45	\$59.12	\$114.05	\$185.12
\$150,000	\$1.04	\$3.81	\$3.81	\$4.78	\$6.58	\$7.27	\$9.35	\$12.81	\$21.81	\$41.19	\$63.35	\$122.19	\$198.35
\$200,000	\$1.38	\$5.08	\$5.08	\$6.37	\$8.77	\$9.69	\$12.46	\$17.08	\$29.08	\$54.92	\$84.46	\$162.92	\$264.46
\$250,000	\$1.73	\$6.35	\$6.35	\$7.96	\$10.96	\$12.12	\$15.58	\$21.35	\$36.35	\$68.65	\$105.58	\$203.65	\$330.58
\$300,000	\$2.08	\$7.62	\$7.62	\$9.55	\$13.15	\$14.54	\$18.69	\$25.62	\$43.62	\$82.38	\$126.69	\$244.38	\$396.69
\$350,000	\$2.42	\$8.88	\$8.88	\$11.15	\$15.35	\$16.96	\$21.81	\$29.88	\$50.88	\$96.12	\$147.81	\$285.12	\$462.81
\$400,000	\$2.77	\$10.15	\$10.15	\$12.74	\$17.54	\$19.38	\$24.92	\$34.15	\$58.15	\$109.85	\$168.92	\$325.85	\$528.92
\$450,000	\$3.12	\$11.42	\$11.42	\$14.33	\$19.73	\$21.81	\$28.04	\$38.42	\$65.42	\$123.58	\$190.04	\$366.58	\$595.04
\$500,000	\$3.46	\$12.69	\$12.69	\$15.92	\$21.92	\$24.23	\$31.15	\$42.69	\$72.69	\$137.31	\$211.15	\$407.31	\$661.15
\$550,000	\$3.81	\$13.96	\$13.96	\$17.52	\$24.12	\$26.65	\$34.27	\$46.96	\$79.96	\$151.04	\$232.27	\$448.04	\$727.27
\$600,000	\$ 4.15	\$15.23	\$15.23	\$19.11	\$26.31	\$29.08	\$37.38	\$51.23	\$87.23	\$164.77	\$253.38	\$488.77	\$793.38
\$650,000	\$ 4.50	\$16.50	\$16.50	\$20.70	\$28.50	\$31.50	\$40.50	\$55.50	\$94.50	\$178.50	\$274.50	\$529.50	\$859.50

Insurance products issued by Dearborn Life Insurance Company, 701 E. 22nd St. Suite 300, Lombard, IL 60148. Blue Cross and Blue Shield of Illinois is the trade name of Dearborn Life Insurance Company, an independent licensee of the Blue Cross and Blue Shield Association. BLUE CROSS®, BLUE SHIELD® and the Cross and Shield Symbols are registered service marks of the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans. Policy Provisions may vary by state. Refer to a certificate or enrollment brochure for details about coverage features and limitations.

Harlem Consolidated School District #122

Eligibility

All eligible, active full time employees

Supplemental Life and AD&D

Employee Benefit: **\$20,000 to \$800,000 in \$10,000 increments.**

Spouse Benefit: **\$10,000 to \$50,000 in \$5,000 increments.
(not to exceed 50% of the employee benefit)**

Note: Spouse may not have coverage unless the employee has coverage.

The spouse benefit may not exceed the employee benefit amount.

Guarantee Issue*

Employee	\$150,000
Spouse	\$50,000

*new hires

Child Coverage

Birth to 15 days:	\$100
15 days to 6 months:	\$250
6 months to age 26:	\$10,000

Life and AD&D benefits reduce by 35% of the original amount at age 65 and further reduce by 60% of the original amount at age 70. 80% of the original amount at age 75.

Supplemental Life and AD&D

Premium Cost (Based on 26 payroll deductions per year)

Benefit Amount	Spouse AD&D	ATTAINED AGE											
		<20	20-24	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70-74
\$10,000	\$0.07	\$0.25	\$0.25	\$0.32	\$0.44	\$0.48	\$0.62	\$0.85	\$1.45	\$2.75	\$4.22	\$8.15	\$13.22
\$15,000	\$0.10	\$0.38	\$0.38	\$0.48	\$0.66	\$0.73	\$0.93	\$1.28	\$2.18	\$4.12	\$6.33	\$12.22	\$19.83
\$20,000	\$0.14	\$0.51	\$0.51	\$0.64	\$0.88	\$0.97	\$1.25	\$1.71	\$2.91	\$5.49	\$8.45	\$16.29	\$26.45
\$25,000	\$0.17	\$0.63	\$0.63	\$0.80	\$1.10	\$1.21	\$1.56	\$2.13	\$3.63	\$6.87	\$10.56	\$20.37	\$33.06
\$30,000	\$0.21	\$0.76	\$0.76	\$0.96	\$1.32	\$1.45	\$1.87	\$2.56	\$4.36	\$8.24	\$12.67	\$24.44	\$39.67
\$35,000	\$0.24	\$0.89	\$0.89	\$1.11	\$1.53	\$1.70	\$2.18	\$2.99	\$5.09	\$9.61	\$14.78	\$28.51	\$46.28
\$40,000	\$0.28	\$1.02	\$1.02	\$1.27	\$1.75	\$1.94	\$2.49	\$3.42	\$5.82	\$10.98	\$16.89	\$32.58	\$52.89
\$45,000	\$0.31	\$1.14	\$1.14	\$1.43	\$1.97	\$2.18	\$2.80	\$3.84	\$6.54	\$12.36	\$19.00	\$36.66	\$59.50
\$50,000	\$0.35	\$1.27	\$1.27	\$1.59	\$2.19	\$2.42	\$3.12	\$4.27	\$7.27	\$13.73	\$21.12	\$40.73	\$66.12

Spouse	
Supplemental Life	
Monthly rates per \$1,000	
Age	Rates
Under 20	\$0.055
20-24	\$0.055
25-29	\$0.069
30-34	\$0.095
35-39	\$0.105
40-44	\$0.135
45-49	\$0.185
50-54	\$0.315
55-59	\$0.595
60-64	\$0.915
65-69	\$1.765
70-74	\$2.865
75+	*

*Please contact your HR Department

Supplemental AD&D	
Monthly rates per \$1,000	
Spouse	Rates
Spouse	\$0.015

Dependent Life (Children)		
Monthly Premium per Family		
	Life	AD&D
\$10,000	\$2.55	\$0.15

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EMPLOYEE ASSISTANCE PROGRAM

EMPLOYEE ASSISTANCE PROGRAM—GUIDANCE RESOURCES ONLINE

Insured by BCBSIL Dearborn through GuidanceResources

What you want. When you want it.

Access your GuidanceResources services anytime, anywhere from your computer, tablet or smartphone. Our award-winning portal, GuidanceResources® Online, is your go-to site for expert information and tools on the issues that matter most to you: relationships, work, school, parenting, wellness, legal, financial, free time and much more. With 24/7 access, you can get the info you need when and where you need it.

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- Marital and family conflicts
- Alcohol or drug use
- Job pressures
- Dealing with change
- Grief and loss

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TDD: 800.697.0353

Online: guidanceresources.com

App: GuidanceResources® Now

Web ID: DISRES

EMPLOYEE CONTRIBUTIONS

EMPLOYEE CONTRIBUTIONS FOR 2026

SUPPORT STAFF	SEMI-MONTHLY
MEDICAL PLAN 1—\$1,000 DEDUCTIBLE & DENTAL	
Employee	\$20.00
Employee + Spouse	\$135.50
Employee + Child	\$100.00
Employee + Child(ren)	\$142.50
Family	\$208.50
MEDICAL PLAN 2—\$1,500 DEDUCTIBLE & DENTAL	
Employee	\$0.00
Employee + Spouse	\$110.50
Employee + Child	\$75.00
Employee + Child(ren)	\$117.50
Family	\$183.50
MEDICAL PLAN 3—H.S.A. PLAN & DENTAL	
Employee	\$0.00
Employee + Spouse	\$58.00
Employee + Child	\$20.50
Employee + Child(ren)	\$65.50
Family	\$111.00
VOLUNTARY VISION RATES	
Employee	\$4.62
Employee + Spouse	\$7.38
Employee + Child(ren)	\$7.53
Family	\$12.14

CERTIFIED STAFF	SEMI-MONTHLY
MEDICAL PLAN 1—\$1,000 DEDUCTIBLE & DENTAL	
Employee	\$30.00
Employee + Spouse	\$177.50
Employee + Child	\$132.50
Employee + Child(ren)	\$187.50
Family	\$267.50
MEDICAL PLAN 2—\$1,500 DEDUCTIBLE & DENTAL	
Employee	\$20.00
Employee + Spouse	\$152.50
Employee + Child	\$117.50
Employee + Child(ren)	\$162.50
Family	\$237.50
MEDICAL PLAN 3—H.S.A. PLAN & DENTAL	
Employee	\$0.00
Employee + Spouse	\$95.50
Employee + Child	\$47.50
Employee + Child(ren)	\$106.00
Family	\$164.50
VOLUNTARY VISION RATES	
Employee	\$4.62
Employee + Spouse	\$7.38
Employee + Child(ren)	\$7.53
Family	\$12.14

Notes: Tobacco surcharge is \$30 per month additional for each medical plan. See Wellness Coordinator for policy and any information pertaining to the wellness program is available on the Harlem CSD 122 web site under Human Resources.

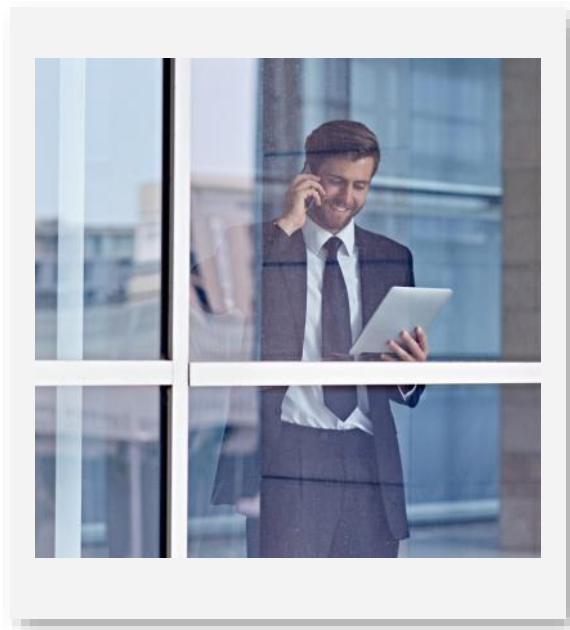
The Harlem CSD 122 medical plans have a “spouse carve-out.” You cannot enroll in the H.S.A. plan, if your spouse has other Traditional PPO coverage as primary. Your spouse must take their employer-sponsored health coverage regardless of plan or cost. Affidavit form is required annually. Secondary spouse coverage is not eligible for the Harlem Health Clinic or ZERO.

If you are enrolling a spouse for coverage, see Human Resources for an annual Affidavit form or policy.

CONTACT INFORMATION

If you have specific questions about a benefit plan, please contact the administrator listed below, or your local human resources department.

BENEFIT	ADMINISTRATOR	PHONE	WEBSITE/EMAIL
Medical	Blue Cross Blue Shield of Illinois	800-458-6024	www.bcbsil.com
Prescription Retail Drugs - Performance Select Formulary	Prime Therapeutics	800-423-1973	www.myprime.com
Prescription Mail Order	Express Scripts (ESI)	833-715-0942	express-scripts.com/rx
Specialty Pharmacy	Accredo	833-721-1619	www.myprime.com
ZERO	ZERO	855-816-0001	https://zero.health
Dental <i>(Included with medical—not available separately)</i>	Delta Dental Plan of Illinois	800-323-1743	www.deltadentalil.com PPO & Premier Networks
Voluntary Vision	VSP	800-877-7195	www.vsp.com Signature Network
Flexible Spending Account	TASC	800-422-4661	www.tasconline.com
Employee Assistance Program	GuidanceResources	866-899-1363	www.guidanceresources.com Web ID: DISRES
Human Resources	Mari-Jo Reed	779-771-5454	mari-jo.reed@harlem122.org
Claims Assistance	Jeanette Rowan Gallagher Benefit Services, Inc.	815-978-7134	Jeanette_Rowan@ajg.com



LEGAL NOTICES

WOMEN'S HEALTH & CANCER RIGHTS ACT

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

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

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under the plan. Therefore, the following deductibles and coinsurance apply:

PPO PLANS

Plan 1: \$1,000 Deductible (Individual: 80% coinsurance and \$1,000 deductible; Family: 80% coinsurance and N/A deductible)

Plan 2: \$1,500 Deductible (Individual: 80% coinsurance and \$1,500 deductible; Family: 80% coinsurance and N/A deductible)

HDHP / H.S.A. PLAN

Plan 3: H.S.A. Plan (Individual: 80% coinsurance and \$3,400 deductible; Family: 80% coinsurance and \$6,000 deductible)

If you would like more information on WHCRA benefits, please call your Plan Administrator, Mari-Jo Reed, at 779-771-5454 or mari-jo.reed@harlem122.org.

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 insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

LEGAL NOTICES

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, 2025. Contact your State for more information on eligibility –

ALABAMA – Medicaid	ALASKA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	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	CALIFORNIA – Medicaid
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	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+)	FLORIDA – Medicaid
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	Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268

LEGAL NOTICES

GEORGIA – Medicaid	INDIANA – Medicaid
<p>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</p>	<p>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</p>
IOWA – Medicaid and CHIP (Hawki)	KANSAS – Medicaid
<p>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</p>	<p>Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-800-967-4660</p>
KENTUCKY – Medicaid	LOUISIANA – Medicaid
<p>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: KIHIPPPROGRAM@ky.gov KCHIP Website: https://kynect.ky.gov Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms</p>	<p>Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)</p>
MAINE – Medicaid	MASSACHUSETTS – Medicaid and CHIP
<p>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</p>	<p>Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: 711 Email: masspremassistance@accenture.com</p>
MINNESOTA – Medicaid	MISSOURI – Medicaid
<p>Website: https://mn.gov/dhs/health-care-coverage/ Phone: 1-800-657-3672</p>	<p>Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005</p>
MONTANA – Medicaid	NEBRASKA – Medicaid
<p>Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HSHIPPProgram@mt.gov</p>	<p>Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178</p>

LEGAL NOTICES

NEVADA – Medicaid	NEW HAMPSHIRE – Medicaid
<p>Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900</p>	<p>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</p>
NEW JERSEY – Medicaid and CHIP	NEW YORK – Medicaid
<p>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)</p>	<p>Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831</p>
NORTH CAROLINA – Medicaid	NORTH DAKOTA – Medicaid
<p>Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100</p>	<p>Website: https://www.hhs.nd.gov/healthcare Phone: 1-844-854-4825</p>
OKLAHOMA – Medicaid and CHIP	OREGON – Medicaid and CHIP
<p>Website: http://www.insureoklahoma.org Phone: 1-888-365-3742</p>	<p>Website: http://healthcare.oregon.gov/Pages/index.aspx Phone: 1-800-699-9075</p>
PENNSYLVANIA – Medicaid and CHIP	RHODE ISLAND – Medicaid and CHIP
<p>Website: https://www.pa.gov/en/services/dhs/apply-for-medicoid-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)</p>	<p>Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct Rlte Share Line)</p>
SOUTH CAROLINA – Medicaid	SOUTH DAKOTA - Medicaid
<p>Website: https://www.scdhhs.gov Phone: 1-888-549-0820</p>	<p>Website: http://dss.sd.gov Phone: 1-888-828-0059</p>
TEXAS – Medicaid	UTAH – Medicaid and CHIP
<p>Website: Health Insurance Premium Payment (HIPP) Program Texas Health and Human Services Phone: 1-800-440-0493</p>	<p>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/</p>

LEGAL NOTICES

VERMONT – Medicaid	VIRGINIA – Medicaid and CHIP
<p>Website: Health Insurance Premium Payment (HIPP) Program Department of Vermont Health Access Phone: 1-800-250-8427</p>	<p>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</p>
WASHINGTON – Medicaid	WEST VIRGINIA – Medicaid and CHIP
<p>Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022</p>	<p>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)</p>
WISCONSIN – Medicaid and CHIP	WYOMING – Medicaid
<p>Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002</p>	<p>Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269</p>

To see if any other states have added a premium assistance program since July 31, 2025, 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)

LEGAL NOTICES

HIPAA NOTICE OF PRIVACY PRACTICES REMINDER

Protecting Your Health Information Privacy Rights

Harlem CSD 122 is committed to the privacy of your health information. The administrators of the Harlem CSD 122 Health Plan (the "Plan") use strict privacy standards to protect your health information from unauthorized use or disclosure.

The Plan's policies protecting your privacy rights and your rights under the law are described in the Plan's Notice of Privacy Practices. You may receive a copy of the Notice of Privacy Practices by contacting Mari-Jo Reed - Benefit Specialist at 779-771-5454 or mari-jo.reed@harlem122.org.

HIPAA SPECIAL ENROLLMENT RIGHTS

Harlem CSD 122 Health Plan Notice of Your HIPAA Special Enrollment Rights

Our records show that you are eligible to participate in the Harlem CSD 122 Health Plan (to actually participate, you must complete an enrollment form and pay part of the premium through payroll deduction).

A federal law called HIPAA requires that we notify you about an important provision in the plan - your right to enroll in the plan under its "special enrollment provision" if you acquire a new dependent, or if you decline coverage under this plan for yourself or an eligible dependent while other coverage is in effect and later lose that other coverage for certain qualifying reasons.

Loss of Other Coverage (Excluding Medicaid or a State Children's Health Insurance Program). If you decline enrollment for yourself or for an eligible dependent (including your spouse) while other health insurance or group health plan coverage is in effect, 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).

Loss of Coverage for Medicaid or a State Children's Health Insurance Program. If you decline enrollment for yourself or for an eligible dependent (including your spouse) while Medicaid coverage or coverage under a state children's health insurance program is in effect, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage. However, you must request enrollment within 60 days after your or your dependents' coverage ends under Medicaid or a state children's health insurance program.

New Dependent by Marriage, Birth, Adoption, or Placement for Adoption. 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 new dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

Eligibility for Premium Assistance Under Medicaid or a State Children's Health Insurance Program – If you or your dependents (including your spouse) become eligible for a state premium assistance subsidy from Medicaid or through a state children's health insurance program with respect to coverage under this plan, you may be able to enroll yourself and your dependents in this plan. However, you must request enrollment within 60 days after your or your dependents' determination of eligibility for such assistance.

To request special enrollment or to obtain more information about the plan's special enrollment provisions, contact Mari-Jo Reed - Benefit Specialist at 779-771-5454 or mari-jo.reed@harlem122.org.

Important Warning

If you decline enrollment for yourself or for an eligible dependent, you must complete our form to decline coverage. On the form, you are required to state that coverage under another group health plan or other health insurance coverage (including Medicaid or a state children's health insurance program) is the reason for declining enrollment, and you are asked to identify that coverage. If you do not complete the form, you and your dependents will not be entitled to special enrollment rights upon a loss of other coverage as described above, but you will still have special enrollment rights when you have a new dependent by marriage, birth, adoption, or placement for adoption, or by virtue of gaining eligibility for a state premium assistance subsidy from Medicaid or through a state children's health insurance program with respect to coverage under this plan, as described above. If you do not gain special enrollment rights upon a loss of other coverage, you cannot enroll yourself or your dependents in the plan at any time other than the plan's annual open enrollment period, unless special enrollment rights apply because of a new dependent by marriage, birth, adoption, or placement for adoption, or by virtue of gaining eligibility for a state premium assistance subsidy from Medicaid or through a state children's health insurance program with respect to coverage under this plan.

LEGAL NOTICES

NOTICE OF CREDITABLE COVERAGE

Important Notice from Harlem CSD 122 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 Harlem CSD 122 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. Harlem CSD 122 has determined that the prescription drug coverage offered by the medical plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join a Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th. However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

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

If you decide to join a Medicare drug plan, your current Harlem CSD 122 coverage will be affected. The Harlem prescription drug plan does not coordinate benefits with Medicare.

If you do decide to join a Medicare drug plan and drop your current Harlem CSD 122 coverage, be aware that you and your dependents may not be able to get this coverage back.

When Will You Pay a Higher Premium (Penalty) to Join a Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with Harlem CSD 122 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.

LEGAL NOTICES

For More Information About This Notice or Your Current Prescription Drug Coverage...

Contact the person listed below for further information. **NOTE:** You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through Harlem CSD 122 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:	October 15, 2025
Name of Entity/Sender:	Harlem CSD 122
Contact—Position/Office:	Mari-Jo Reed - Benefit Specialist
Office Address:	8605 N 2nd St Machesney Park, Illinois 61115-2003 United States
Phone Number:	779-771-5454

LEGAL NOTICES

WELLNESS PROGRAM DISCLOSURES

Your health plan is committed to helping you achieve your best health. Rewards for participating in a wellness program are available to all employees. If you think you might be unable to meet a standard for a reward under this wellness program, you might qualify for an opportunity to earn the same reward by different means. Contact Diana Disch, Wellness Coordinator, at 815-654-4500 Ext. 1031, and we will work with you (and, if you wish, with your doctor) to find a wellness program with the same reward that is right for you in light of your health status.

NOTICE REGARDING WELLNESS PROGRAM

The Harlem CSD 122 wellness program is a voluntary wellness program available to all employees. The program is administered according to federal rules permitting employer-sponsored wellness programs that seek to improve employee health or prevent disease, including the Americans with Disabilities Act of 1990, the Genetic Information Nondiscrimination Act of 2008, and the Health Insurance Portability and Accountability Act, as applicable, among others. If you choose to participate in the wellness program you will be asked to complete a voluntary health risk assessment or "HRA" that asks a series of questions about your health-related activities and behaviors and whether you have or had certain medical conditions (e.g., cancer, diabetes, or heart disease). You will also be asked to complete a biometric screening, which will include blood pressure reading, total cholesterol, HDL, Triglycerides, LDL, A1C or Fasting Glucose. You are not required to complete the HRA or to participate in the blood test or other medical examinations.

Eligible employees can avoid the following monthly and progressive surcharge on insurance premiums by completing the wellness plan requirements (see below Steps 1 & 2 "Required to Avoid Surcharge"):

- \$75.00 per month - Year 1
- \$100.00 per month - Year 2 and subsequent years

Step 1 - Required to avoid surcharge for Employee & Spouse - Complete Annual Biometric Screening and Annual BCBSIL Well onTarget online Health Risk Assessment (HRA).

Step 2 - Required to avoid surcharge for Employee - Complete Annual Preventive Screenings, Vaccines/Boosters, Chronic Disease Management, Seminars/Webinars (limited to a max of 2 points).

Although you are not required to complete the HRA or participate in the biometric screening, only employees and spouses who do so will receive wellness plan incentives. **Wellness documents must be received no later than November 30th of each respective wellness year to be considered.**

If you are unable to participate in any of the health-related activities or achieve any of the health outcomes required to earn an incentive, you may be entitled to a reasonable accommodation or an alternative standard. You may request a reasonable accommodation or an alternative standard by contacting Diana Disch, Wellness Coordinator, at 815-654-4500 Ext. 1031.

The information from your HRA and the results from your biometric screening will be used to provide you with information to help you understand your current health and potential risks, and may also be used to offer you services through the wellness program, such as chronic condition management. You also are encouraged to share your results or concerns with your own doctor. Protections from Disclosure of Medical Information.

We are required by law to maintain the privacy and security of your personally identifiable health information. Although the wellness program and Harlem CSD 122 may use aggregate information it collects to design a program based on identified health risks in the workplace, Harlem CSD 122 and Marathon Health will never disclose any of your personal information either publicly or to the employer, except as necessary to respond to a request from you for a reasonable accommodation needed to participate in the wellness program, or as expressly permitted by law. Medical information that personally identifies you that is provided in connection with the wellness program will not be provided to your supervisors or managers and may never be used to make decisions regarding your employment.

LEGAL NOTICES

WELLNESS PROGRAM DISCLOSURES (Cont.)

Your health information will not be sold, exchanged, transferred, or otherwise disclosed except to the extent permitted by law to carry out specific activities related to the wellness program, and you will not be asked or required to waive the confidentiality of your health information as a condition of participating in the wellness program or receiving an incentive. Anyone who receives your information for purposes of providing you services as part of the wellness program will abide by the same confidentiality requirements. The only individual(s) who will receive your personally identifiable health information is (are) Harlem's clinic providers and health coach in order to provide you with services under the wellness program.

In addition, all medical information obtained through the wellness program will be maintained separate from your personnel records, information stored electronically will be encrypted, and no information you provide as part of the wellness program will be used in making any employment decision. Appropriate precautions will be taken to avoid any data breach, and in the event a data breach occurs involving information you provide in connection with the wellness program, we will notify you immediately.

You may not be discriminated against in employment because of the medical information you provide as part of the participating in the wellness program, nor may you be subjected to retaliation if you choose not to participate. If you have questions or concerns regarding this notice, or about protections against discrimination and retaliation, please contact Diana Disch, Wellness Coordinator, at 815-654-4500 Ext. 1031.

LEGAL NOTICES

MARKETPLACE NOTICE

Health Insurance Marketplace Coverage Options and Your Health Coverage

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.

LEGAL NOTICES

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](https://www.healthcare.gov) and either- submit a new application or update an existing application on [HealthCare.gov](https://www.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](https://www.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 Mari-Jo Reed.

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit [HealthCare.gov](https://www.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.

LEGAL NOTICES

3. Employer name Harlem CSD 122		4. Employer Identification Number (EIN) 36-6005746	
5. Employer address 8605 N 2nd St		6. Employer phone number 779-771-5454	
7. City Machesney Park	8. State Illinois	9. ZIP code 61115-2003	
10. Who can we contact about employee health coverage at this job? Mari-Jo Reed			
11. Phone number (if different from above)		12. Email address mari-jo.reed@harlem122.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: See Collective Bargaining Agreement

Some employees. Eligible employees are:

- With respect to dependents:

We do offer coverage. Eligible dependents are:

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, provides minimum value and coverage satisfies an affordability safe harbor.

****** 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](https://www.healthcare.gov) will guide you through the process. Here's the employer information you'll enter when you visit [HealthCare.gov](https://www.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)

LEGAL NOTICES

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? HDHP \$0

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)

LEGAL NOTICES

ILLINOIS DEPENDENT ELIGIBILITY MANDATE

Under Federal law, your dependents are eligible for health and dental coverage up to the dependent limiting age and may not be denied coverage due to marital, student or employment status before age 26. Check with your employer for additional details regarding eligibility requirements. In addition, eligible military personnel may not be denied coverage before age 30 under Illinois law.

This Illinois law applies to all individual plans and insured group medical and dental plans, as well as self-insured municipalities, counties and schools. The law does not apply to self-funded national account groups or local non-municipal self-funded groups. If you have questions about this law, contact your benefits administrator.

NOTES



This benefit summary prepared by



Insurance | Risk Management | Consulting