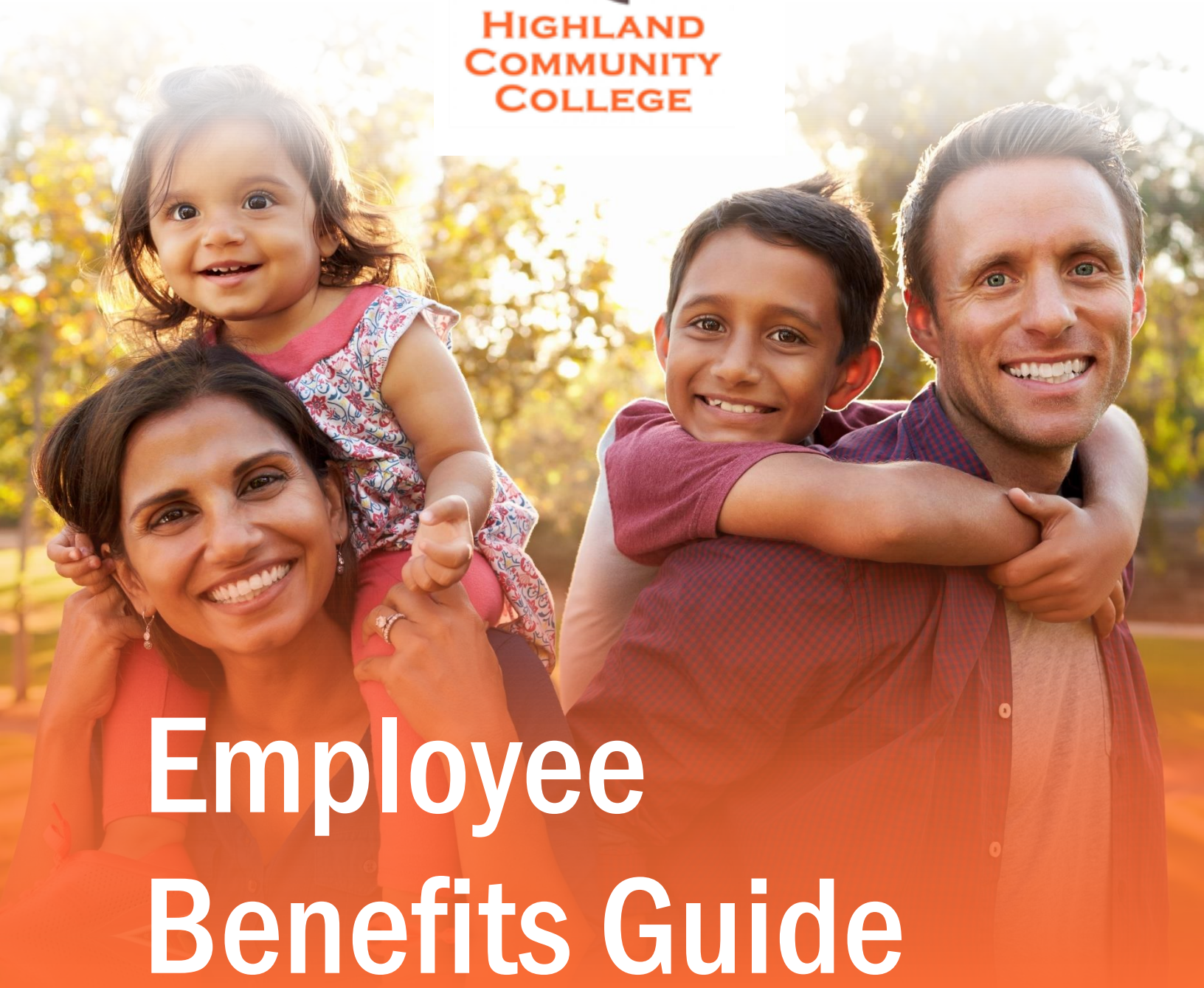
HIGHLAND COMMUNITY COLLEGE



Employee Benefits Guide

Your Benefits, Your Choice

2019 - 2020

CONTENTS

BENEFIT HIGHLIGHTS

WELCOME TO YOUR EMPLOYEE BENEFITS!

At Highland Community College we are proud to offer our employees a wide variety of benefits to choose from, at the most affordable prices available.

We believe our commitment to your health and financial well-being is an important aspect of what we offer as an employer and we strive to provide enough choices that every individual and family can be appropriately covered through all stages of life.

Within this guide you will find the highlights of each benefit. When you choose to enroll in a benefit, the premium will be conveniently payroll deducted so that you never have to worry about paying a bill. Some benefits are even paid for entirely by Highland Community College!

Current Employees

Open enrollment takes place in May! This is your chance to make changes to your benefits and add or drop dependents. You will not get another chance to do this until the next open enrollment, unless you experience a qualifying life event. Please make sure to enroll or make benefit changes before the deadline and come to us with any questions you have before that time. Thank you again for your service to the company!

New Employees

Right now is your chance to elect the coverage you want for yourself and your family for July 1, 2019 – June 30, 2020. We encourage you to read through this guide, share it with your family members, and ask us any questions that you may have so that you are educated and empowered to choose the benefits that are best for you. You have 31 days to enroll in benefits because they will become effective on the first day of employment. If you don't take action now, you will not have the opportunity to enroll again until the next open enrollment period in May, unless you experience a qualifying life event.

CONTACTS

COVERAGE	CARRIER	PHONE NUMBER	WEBSITE/EMAIL
Medical Insurance	BCBS of IL	800-541-2768	www.bcbsil.com
Dental Insurance	BCBS/Dearborn National	800-541-2768	www.bcbsil.com
Vision Insurance	BCBS/Dearborn National Powered by EyeMed	844-323-8302	dearbornnational.com
Flexible Spending Account	SISCO	800-457-4726	www.siscobenefits.com
Virtual Visit	MDLive	800-676-4204	www.MDLIVE.com/bcbsil
Critical Illness Insurance	Dearborn National	844-323-8302	dearbornnational.com
Accident Insurance	Dearborn National	844-323-8302	dearbornnational.com

HIGHLAND COMMUNITY COLLEGE BENEFITS CONTACT		
Karen Brown	815-599-3402	Karen.brown@highland.edu
Sandy Johnson	815-599-3426	sandy.johnson@highland.edu

DISCLAIMER: The information described within this guide is only intended to be a summary of your benefits. It does not describe or include all benefit provisions, limitations, exclusions, or qualifications for coverage. Please review your Summary Plan Description for a complete explanation of your benefits. If the benefits described herein conflict in any way with the Summary Plan Description, the Summary Plan Description will prevail. You can obtain a copy of the Summary Plan Description from the Human Resources Department.

ELIGIBILITY & ENROLLMENT

Employee Eligibility

All full-time employees who are regularly scheduled to work 30 or more hours per week will be eligible for benefits. As a new employee, you have **31** days from your initial start date to enroll in benefits.

- Medical, Dental, Life: Coverages will take effect on the first full day of employment.
- Long Term Disability: Coverage will take effect on the day immediately following the first full day of employment.
- Vision: Coverage will take effect on the first of the month following employment.

**These benefits may require employees to be actively at work at the time benefits become effective. Please review policy documents, or contact HR, for additional information.*

Dependent Eligibility

- Medical, Dental, Vision: Employees enrolled in Medical, Dental, and Vision coverages also have the option to enroll their Dependent Spouse and Dependent Children on these plans. See below for a definition of an "eligible dependent" under these plans.

Definition of "Eligible Dependents"

The below definitions refer to Medical, Dental, and Vision Coverages.

- Your legal spouse or domestic partner who is a resident of the same country in which the Employee resides. The spouse must have met all requirements of a valid marriage contract of the State in which the marriage of such parties was performed. The employee and domestic partner must meet all requirements as stated in the "Affidavit of Domestic Partnership" which must be completed, signed by both partners, dated/notarized and filed with the Human Resources Office.
- The employee's dependent children until the end of the month, in which, they attain age 26, legally adopted children from the date the employee assumes legal responsibility, foster children that live with the employee and for whom the employee is the primary source of financial support, children for whom the employee assumes legal guardianship and stepchildren.
- Also included are the employee's children (or children of the employee's spouse) for whom the employee has legal responsibility resulting from a valid court decree.
- Children who are mentally or physically disabled and totally dependent on the employee for support, past the age of 26 or older. To be eligible for continued coverage past the age of 26, certification of the disability is required within 31 days of attainment of age 26. A certification form is available from the employer or from the claims administrator and may be required periodically. You must notify the claims administrator and/or the employer if the dependent's marital or tax exemption status changes and they are no longer eligible for continued coverage.

Are you ready to enroll? The first step is to review your current benefits. Did you move recently or get married? Verify all of your personal information and make any necessary changes.

Once all your information is up to date, it's time to make your benefit elections. The decisions you make during open enrollment can have a significant impact on your life and finances, so it is important to weigh your options carefully.

When to Enroll

Initial enrollment must be completed within 31 days fo full-time employment. The annual open enrollment is during a two week period beginning in May. The benefits you choose during open enrollment will become effective on July 1.

How to Make Changes

Unless you experience a qualifying life event, you cannot make changes to your benefits until the next open enrollment period. An election change must be made within 31 days of the qualifying event.

Qualifying life events include:

- Marriage, divorce, legal separation or death of a spouse
- Birth or adoption of a child
- Change in child's dependent status
- Death of a spouse, child or other qualified dependent
- Change in employment status or the loss of other coverage.

PER PAY PERIOD (26 WEEKS) EMPLOYEE CONTRIBUTIONS

If you have questions or concerns, please speak with Human Resources.

MEDICAL COVERAGE	Traditional Plan	HDHP (HSA Qualified) Plan
Employee Only	$71.32	$65.63
Family	$178.31	$164.08

DENTAL COVERAGE	
Employee Only	$2.85
Employee + Spouse	$5.79
Employee + Child(ren)	$5.98
Family	$10.68

VISION COVERAGE	
Employee Only	$3.60
Employee + Spouse	$6.84
Employee + Child(ren)	$7.20
Family	$10.59

MEDICAL INSURANCE

Carrier Name

We provide you the option to purchase affordable medical coverage. The below plans allow you to visit any doctor or facility you choose—however, you will get the best coverage when you choose an in-network provider.

MEDICAL COVERAGE HIGHLIGHTS	**Traditional Plan**		**HDHP (HSA Qualified) Plan**	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Annual Deductible				
Individual	$500	$1,000	$1,500	$1,500
Family	$1,500	$3,000	$3,000	$3,000
Coinsurance (percent paid after you reach your annual deductible)				
Plans Pays	90%	70%	100%	80%
You Pay	10%	30%	0%	20%
Annual Out-of-Pocket Maximum				
Individual	$700	$1,400	N/A	
Family	$2,100	$4,200	N/A	
Covered Services				
Preventive Care	100% Covered	30% after deductible	100% Covered	20% after deductible
Primary Care Office Visit	10% after deductible	30% after deductible	100% covered after deductible	20% after deductible
Specialist Office Visit	10% after deductible	30% after deductible	100% covered after deductible	20% after deductible
Urgent Care	10% after deductible	30% after deductible	100% covered after deductible	20% after deductible
Emergency Room	10% after deducible	10% after deductible	10% after deductible	10% after deductible

PRESCRIPTION DRUG COVERAGE HIGHLIGHTS			
Out of Pocket Max	$500 Individual / $1,000 Family		NA
Generic	$10 Copay		20% after deductible
Preferred Brand	$35 Copay		20% after deductible
Non-Preferred Brand	$60 Copay		20% after deductible
Specialty	$150 Copay	Not Covered	20% after deductible

VIRTUAL DOCTOR VISITS

MDLive

Available to all employees, regardless of health plan enrollment.

MDLive can be a great alternative to visiting your normal doctor or an urgent care, when you are suffering from one of many common, non-emergency medical conditions. With 24/7/365 access to U.S. board-certified doctors, you can access medical care for only a $40 copay, from home or on the road—and in some cases, doctors can write a prescription to a local pharmacy near you.*



How Does It Work?

Log in to your account or register if you don't have one set-up. Then, contact MDLive from anywhere—and let the doctor come to you!

MDLive
Phone: 888-676-4202
Online: www.MDLIVE.com/bcbsil

MDLive doctors can then diagnose non-emergency medical problems, recommend treatment, and can even call in a prescription to your pharmacy of choice, when necessary.*

**Prescription services may not be available in all states.*

When Can I Use It?

- When you need care now.
- If you're considering the ER or urgent care center for a non-emergency issue.
- On vacation, on a business trip, or away from home.

Common Conditions We Treat

- Allergies
- Colds, respiratory problems, flu
- Ear infections
- Sore Throat
- Pink eye
- Urinary tract infections
- And more!

Save Money and Time!

For only a $40 copay, MDLive provides significant savings over urgent care and emergency room visits. Plus, you can use it from the convenience of home or work, allowing you to avoid the hassle of sitting in a waiting room.

Meet Our Doctors!

- U.S. board-certified with an average of 15 years of practice experience
- U.S. residents and licensed in your state

DENTAL INSURANCE

BCBS / Dearborn National

Highland Community College offers you the option to buy affordable Dental Insurance through BCBS/Dearborn National. On this plan, you have the option to use any dentist; however, if you go out-of-network, the plan will reimburse based on the "Usual and Customary" fees. See Human Resources for a full summary description of benefits.

To see if your provider is in network, you can visit www.bcbsil.com/providers/dppo.htm

DENTAL COVERAGE HIGHLIGHTS	
Annual Deductible Individual / Family	$50 / $150
Annual Benefit Maximum	$1,000
Orthodontia Lifetime Maximum	$1,000
Preventive Care	100% Covered
Basic Services	20% after deductible
Major Services	50% after deductible
Orthodontia Services	50% after deductible

VISION INSURANCE

BCBS/Dearborn National Powered by EyeMed

The vision plan is a voluntary employee paid benefit and is provided through BCBS/Dearborn National Powered by EyeMed. The plan pays benefits for both in and out of network providers, but benefits will be greater when you utilize in network providers.

To see if your provider is in network, you can visit www.eyemedvisioncare.com/locator using the SELECT network

VISION COVERAGE HIGHLIGHTS	In-Network	Out-of-Network
Exam Once every 12 months	$10 Copay	Up to $30
Lenses Once every 12 months	$10 Copay	See Schedule of Benefits
Frames Once every 24 months	$130 Allowance; then 20% off	Up to $65
Contact Lenses Once every 12 months; in lieu of lenses/frames glasses	$130 Allowance, then 15% off	Up to $104

FLEXIBLE SPENDING ACCOUNTS (FSA)

SISCO

Paying for health care can be stressful. That's why the company offers an employer-sponsored FSA.

What Are the Benefits of a FSA?

There are a variety of different benefits of using a FSA, including the following:

- **It saves you money**. Allows you to put aside money tax-free that can be used for qualified medical expenses.
- **It's a tax-saver**. Since your taxable income is decreased by your contributions, you'll pay less in taxes.
- **It is flexible**. You can use your FSA funds at any time, even if it's the beginning of the year.

You cannot stockpile money in your FSA. **If you do not use, you lose it.** You should only contribute the amount of money you expect to pay out of pocket that year. **The maximum amount you may contribute each year to an FSA in 2020 is $2,750 per year. Note: Even if you signed up last year, you must re-enroll each year.**

What Is a Dependent Care FSA?

Dependent Care FSAs allow you to contribute pre-tax dollars to qualified dependent care. **The maximum amount you may contribute each year is $5,000 (or $2,500 if married and filing separately).**

FSA Case Study

Because FSAs provide you with an important tax advantage that can help you pay for health care expenses on a pre-tax basis. Due to the personal tax savings you incur, your spendable income will increase. The example that follows illustrates how an FSA can save money.

Jane expects to spend $3,000 in medical expenses in the next plan year, she decides to direct a total of $2,750 (the maximum allowed amount per individual, for that taxable year) into their FSAs.

	Without FSA	With FSA
Gross income	$30,000	$30,000
FSA contributions	$0	**-$2,750**
Gross income	$30,000	$27,250
Estimated taxes		
Federal	-$2,550*	-$1,776*
State	-$900**	-$750**
FICA	-$2,295	-$1,913
After-tax earnings	$24,255	$22,811
Eligible out-of-pocket medical expenses	-$3,000	-$300
Remaining spendable income	$21,255	$22,511
Spendable income increase	--	$1,256

**Assumes standard deductions and four exemptions. **Varies, assumes 3 percent. This example is for illustrative purposes only. Every situation varies and it is recommended you consult a tax advisor for all tax advice.*

HEALTH SAVINGS ACCOUNT (HSA)

Available to employees enrolled on the HDHP Medical Plan.

Health savings accounts (HSAs) are a great way to save money and budget for qualified medical expenses. HSAs are tax-advantaged savings accounts that accompany a Health Savings Account Qualified Plan, such as a High Deductible Health Plan (HDHP). HDHPs offer lower monthly premiums in exchange for a higher deductible (the amount you pay before insurance kicks in).

What Are the Benefits of an HSA?

There are many benefits of using an HSA, including the following:

- **It saves you money**. HDHPs have lower monthly premiums, meaning less money is being taken out of your paycheck.
- **It is portable**. The money in your HSA is carried over from year to year and is yours to keep, even if you leave the company.
- **It is a tax-saver**. HSA contributions are made with pre-tax dollars. Since your taxable income is decreased by your contributions, you'll pay less in taxes.

HSA Contribution Limits

The maximum amount that you can contribute to an HSA is $3,550 (individual) or $7,100 (family) in 2020. If you are age 55 or older, you may make an additional "catch-up" contribution of $1,000. You may change your contribution amount at any time throughout the year as long as you don't exceed the annual maximum.

HSA Case Study

Justin is a healthy 28-year-old single man who contributes $1,000 each year to his HSA. His plan's annual deductible is $1,500 for individual coverage. Here is a look at the first two years of Justin's HSA plan, assuming the use of in-network providers. This example only includes HSA contribution amounts and does not reflect any investment earnings.

Year 1		→	Year 2	
HSA Balance	$1,000		HSA Balance	$1,850
Total Expenses: Prescription drugs: $150	(-$150)		Total Expenses: Office visits: $100 Prescription drugs: $200 Preventive care services: $0 (covered by insurance)	(-$300)
HSA Rollover to Year 2	$850	→	HSA Rollover to Year 3	$1,550
Since Justin did not spend all of his HSA dollars, he did not need to pay any additional amounts out-of-pocket this year.			Once again, since Justin did not spend all of his HSA dollars, he did not need to pay any additional amounts out-of-pocket this year.	

For more information on opening a HSA, visit:

https://tinyurl.com/HSATraditional

BASIC LIFE/AD&D INSURANCE

Reliance Standard Life Insurance Company

Life insurance can help provide for your loved ones if something were to happen to you. The company provides full-time employees with $40,000 or 1.5 times annual salary, rounded to the nearest $1,000 (whichever is greater) in group life and accidental death and dismemberment (AD&D) insurance.*

Highland Community College pays for the full cost of this benefit—meaning you are not responsible for paying any monthly premiums.

Contact Human Resources anytime you would like to update your beneficiary information.

Your designated beneficiary will receive a benefit to help ease their financial burden if you die. If you do not update your beneficiaries, it will make it harder for the right person to receive your benefit, if ever needed. Please update your beneficiaries as necessary!

HOW MUCH LIFE INSURANCE COVERAGE DO YOU NEED?

Depending on your personal situation, you may wish to purchase additional coverage that you can buy at affordable group rates.

Use this worksheet to estimate how much additional life insurance you need and see the details of the voluntary life on the following page.

When considering how much life insurance you need, it's important to think about your outstanding debt, ongoing expenses and the future plans of your family. Fill in the blanks to figure out how much life insurance you may wish to purchase.

Outstanding Debt – How much will be left for your family to pay?	
Mortgage balance	$ _____
Other debt (credit cards, loans, car payment)	$ _____
TOTAL (A)	$ _____ (A)
Ongoing Expenses – How much do your dependents need each year?	
Utilities (electric, phone, cable, internet)	$ _____
Medical costs, insurance	$ _____
Food, clothing, gasoline	$ _____
Saving contributions	$ _____
TOTAL (B)	$ _____ (B)
Future Plans – How much will loved ones need for the future?	
College	$ _____
Other (retirement, long term care)	$ _____
TOTAL (C)	$ _____ (C)
Grand Total (A+B+C)	$ _____
Subtract existing coverage	$ _____
Subtract company-paid life	$ _____
Consider this amount of life insurance	$ _____

**AD&D pays a benefit for loss of life or dismemberment resulting from a covered accidental bodily injury. Your beneficiary may receive up to 100% of the AD&D amount if you die as the result of a covered accidental injury. You may receive an accidental dismemberment benefit for losses to a hand, a foot, or the sight of an eye due to an accidental injury. See the policy for exact schedule of losses and benefits.*

Please review the full summary plan documents for a list of your exclusions and limitations. *This plan highlight is a summary provided to help you understand your insurance coverage. Details may differ from state to state. Please refer to your certificate booklet for your complete plan description. If the terms of this plan highlight summary or your certificate differ from your policy, the policy will govern.*

Benefits may be reduced for employees over age 65 per ADEA.

SUPPLEMENTAL TERM LIFE/AD&D INSURANCE

Reliance Standard Life Insurance Company

While Highland Community College offers basic life insurance, some employees may want to purchase additional coverage. Think about your personal circumstances. Are you the sole provider for your household? What other expenses do you expect in the future (for example, college tuition for your child)? Depending on your needs, you may want to consider buying supplemental coverage.

With voluntary life insurance, you are responsible for paying the full cost of coverage through payroll deductions. You can purchase coverage for yourself or for your eligible dependent spouse and child(ren).

NEW HIRE NOTICE! If you are a new hire, this is your chance to receive Guarantee Issue for yourself and your dependents. If you do not take advantage of this benefit at your initial new hire enrollment but then wish to enroll at a later date, you will be subject to evidence of insurability (answer medical questions).

TERM LIFE/AD&D COVERAGE HIGHLIGHTS	
Life/AD&D Benefit Amount	**Employee:** $10,000 to $750,000 in increments of $10,000, not to exceed seven (7) times your annual earnings, subject to evidence of insurability for amounts over Guarantee Issue Limit. **Spouse:** $10,000 to $750,000 in increments of $10,000, subject to evidence of insurability for amounts over Guarantee Issue Limit. Spouse coverage may not exceed employee's amount. **Child(ren):** Choice of $2,500, $5,000, $7,500 or $10,000 for children age 14 days up to age 26 years.
Guarantee Issue Amount	**Employee:** $10,000 to $150,000 in increments of $10,000 **Spouse:** $10,000 to $100,000 in increments of $10,000 **Child(ren):** Choice of $2,500, $5,000, $7,500 or $10,000

Definition of "Eligible Dependents"

- **Spouse** – eligibility will terminate when no longer married.
- **Child** – eligibility terminates earliest of age 26, married, or no longer financially dependent upon you for support. Terms may vary for children with special needs.

Important – Please Read!

- Dependents may have a delayed effective date based on his/her medical status at time of enrollment. Please refer to the policy certificate or Human Resources for more details.
- Please update your beneficiaries periodically! If you do not update your beneficiaries, it will make it harder for the right person to receive your benefit, if ever needed.
- It is the responsibility of the employee to ensure dependents are eligible for coverage under these policies. Please refer to the policy certificate or Human Resources for more information.

Please review the full summary plan documents for a list of your exclusions and limitations. *This plan highlight is a summary provided to help you understand your insurance coverage. Details may differ from state to state. Please refer to your certificate booklet for your complete plan description. If the terms of this plan highlight summary or your certificate differ from your policy, the policy will govern.*

VOLUNTARY LONG-TERM DISABILITY INSURANCE

Reliance Standard Life Insurance Company

While State Universities Retirement System offers short term disability insurance, some employees may want to purchase additional coverage. Think about your personal circumstances. Are you the sole provider for your household? Depending on your needs, you may want to consider buying supplemental coverage. Without disability coverage, you and your family may struggle to get by if you miss work due to an injury or illness. In the event that you become disabled from a non-work-related injury or sickness, disability income benefits may provide a partial replacement of lost income. Please note, though, that you are not eligible to receive disability benefits for work-related disabilities.

LONG-TERM DISABILITY COVERAGE HIGHLIGHTS	
Monthly Benefit Amount	65% (tax-free) of salary to age 65 (maximum monthly benefit is $8,000)
Elimination Period	The greater of 90 consecutive days of Total Disability or a zero balance in eligible sick or sick bank time.
Benefit Duration	Benefits will not accrue beyond the longer of: the Duration of Benefits; or Normal Retirement Age.
Pre-Existing Condition Limitations	If Total Disability begins in the first twenty-four (24) months after the Insured's effective date; review for pre-existing condition may limit benefits. Refer the complete plan description for more information.

SHORT-TERM DISABILITY INSURANCE

State University Retirement System (SURS)

You may be eligible for a disability benefit from the State Universities Retirement System (SURS) after at least two years of service credit and you become unable to perform the duties of your position because of illness or injury. There is no minimum service credit required if you become disabled because of an accident. SURS short-term disability benefits coordinate with long-term disability benefits to ensure that 65% of gross monthly earnings are not exceeded.

SHORT-TERM DISABILITY COVERAGE HIGHLIGHTS	
Monthly Benefit Amount	50% of the monthly salary you were receiving at the time you became disabled or 50% of your average earnings for the 24 months prior to the date you became disabled, whichever is greater.
Elimination Period	The greater of 60 days or the day following the last day you are paid by your employer including pay for all sick leave benefits.
Benefit Duration	Benefit terminates when the conditions of being disabled are no longer met, separation refund is paid, the individual applies for retirement, death or benefit is exhausted. Benefit is exhausted when participant has received 50% of all SURS eligible earnings.

Please review the full summary plan documents for a list of your exclusions and limitations. *This plan highlight is a summary provided to help you understand your insurance coverage. Details may differ from state to state. Please refer to your certificate booklet for your complete plan description. If the terms of this plan highlight summary or your certificate differ from your policy, the policy will govern.*

CRITICAL ILLNESS INSURANCE

Dearborn National

If you are diagnosed with a critical illness, critical illness insurance can help you pay for expenses that aren't covered by your existing health insurance plan. Critical illness coverage pays you a lump-sum cash benefit to help pay for treatment or bills. Additionally, there is a $50 wellness benefit per calendar year for each insured person to help cover the cost of certain wellness tests.

Some covered illnesses include heart attack, stroke, major organ failure, paralysis, benign brain tumor, coma, loss of sight, speech, or hearing, and major burns. For more information or a list of your employee rates, see Human Resources.

CRITICAL ILLNESS COVERAGE HIGHLIGHTS	
Employee	$5,000 or $10,000 increments
Spouse	$2,500 or $5,000 increments
Child(ren)	$2,500

ACCIDENT INSURANCE

Dearborn National

If you are accidentally injured, accident insurance can help you take care of out-of-pocket expenses and medical costs beyond what your existing health insurance plan covers. Additionally, there is a wellness benefit to help cover the cost of certain wellness tests once per calendar year.

Some covered accident insurance benefits include: hospital confinement, ambulance bills, dislocation or fractures, accidental death and dismemberment, and medical expenses. For more information or a list of your employee rates, see Human Resources.

ACCIDENT COVERAGE HIGHLIGHTS (EMPLOYEE-PAID)	
Coverage Amounts	See Schedule of Benefits allowance amounts

Please review the full summary plan documents for a list of your exclusions and limitations. *This plan highlight is a summary provided to help you understand your insurance coverage. Details may differ from state to state. Please refer to your certificate booklet for your complete plan description. If the terms of this plan highlight summary or your certificate differ from your policy, the policy will govern.*

RETIREMENT

State Universities Retirement System (SURS)

No matter where you are in your life, saving for retirement can be a challenging task. Luckily, there are tools you can use to help you meet your goals. Highland Community College offers ways to set you up for life beyond the workforce.

SURS provides retirement, disability, death, and survivors' benefits to all eligible SURS participants and annuitants. As required by state law, SURS generally covers all faculty and nonacademic employees of State universities, colleges, and community colleges. Employees must elect one of the three SURS retirement plans in which to participate. All eligible employees will contribute 8% of gross compensation to the State Universities Retirement Plan pre-taxed. The State of Illinois also contributes 8%. Your contributions into SURS will provide you with a monthly income when you retire. The amount of the income is dependent upon your years of service and the retirement plan chosen. There are two tiers of employees associated with SURS. Tier I employees were first employed under SURS prior to January 1, 2011. Tier II employees were first employed on January 1, 2011 or after.

RETIREMENT COVERAGE HIGHLIGHTS		
	Tier I	Tier II (Tier II employees electing the self-managed plan, will follow Tier I)
Minimum Vesting	5 years of service	10 years of service
Normal Retirement Age (without age reduction)	Age 62, with at least 5 years of service Age 60, with at least 8 years of service At any age with at least 30 years of service	Age 67 with at least 10 years of service

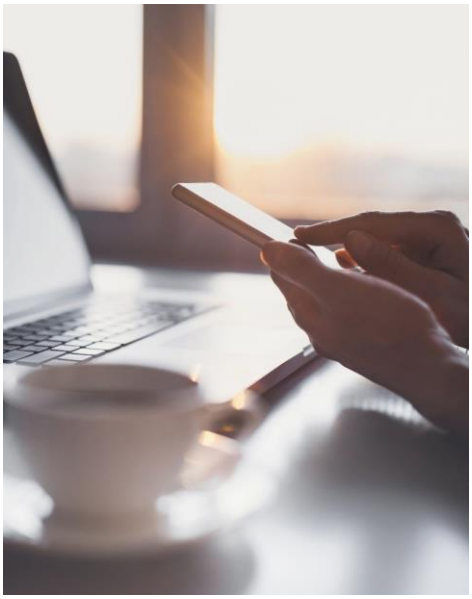
Tax-Deferred Annuities – 403(b)Plan

To supplement SURS, salary reductions for tax-deferred annuities are available to all full-time and part-time employees in accordance with Section 403(b) of the Internal Revenue Code, as amended. Tax-deferred annuities allow employees a method of saving for retirement by redirecting a portion of their pre-tax earnings to a tax-deferred annuity plan as offered by the College. Faculty and custodial/maintenance employees covered under their respective union agreements receive an employer match for 403(b) contributions up to a certain amount. Collective bargaining agreements for FY20 are still under negotiation. For FY19, faculty were eligible to receive a match up to $2,250 and custodial/maintenance employees were eligible to receive up to $575.

EMPLOYEE ASSISTANCE PROGRAMS

Sojourn House, Inc.

We all experience personal problems. We solve most of them ourselves. However, there are certain behavioral, personal, emotional or medical problems such as psychiatric illness, family crises, alcoholism, drug dependence and financial problems that require professional guidance and/or treatment.



Getting Help

Everyone experiences periods of stress. Some stress is normal, but if your feelings of stress become persistent and overwhelming it may be an indication of a serious medical problem.

The Highland Community College EAP is designed to provide assistance in the form of confidential referral for evaluation and recommendations for treatment of persistent behavioral, personal, emotional, or medical concerns which interfere with the quality of life.

The objectives of the Employee Assistance Program are:

1. To motivate employees to seek help before personal problems reach severe or chronic stages.
2. To restore employee productivity and enable employees to lead meaningful and happy lives.
3. To provide help in a confidential manner.

Professional Assistance

Sojourn House, Inc. administers the necessary services for development and implementation of the Employee Assistance Program at HCC. Sojourn has a professional Employee Assistance Program referral coordinator who is not an employee of HCC to discuss and employee's problem on a strictly confidential basis. The employee may contact the referral coordinator independently of upon referral by his/her supervisor. This discussion may be accomplished via phone or by appointment in the coordinator's office. During this time the referral coordinator will assess the nature of the problem and make a referral to the appropriate resource for immediate assistance. There is no cost for this initial evaluation interview. Any further treatment required may be reimbursed by medical insurance plans. The referral coordinator will work with the employee to obtain the best possible treatment within the employee's budgetary limitations.

Eligibility

The Highland Community College Employee Assistance Program is available to full-time employees who have completed 90 days of employment and their immediate family members.

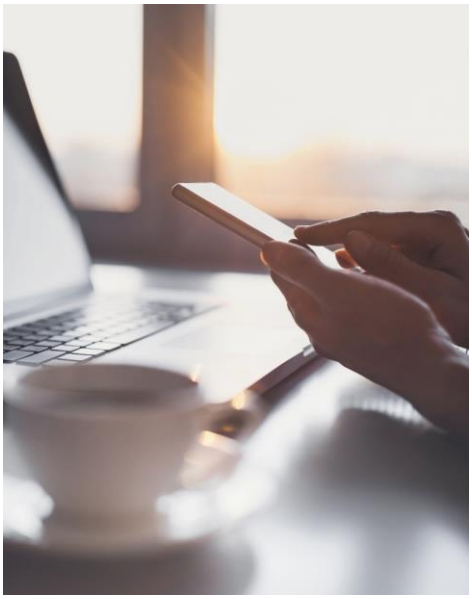
Confidentiality

A key element to the program is confidentiality.

Who to Contact for Help

If an employee or immediate family member wishes to self-refer to the EAP, he/she should do one of the following:

1. Call 815-232-5121. This is the EAP line at Sojourn House, Inc. Identify yourself as an employee of HCC, and ask for the EAP referral coordinator. You do not have to provide your name unless you choose to do so.
2. Contact Human Resources at extension 3402 for assistance in scheduling an appointment.



ACI Specialty Benefits

ACI's Employee Assistance Program (EAP), under agreement with Reliance Standard Life Insurance Company, provides professional and confidential services by phone and online to help employees and family members address a variety of personal, family, life, and work-related issues.

EAP and Work-Life Benefits

From the stress of everyday life to relationship issues or even work-related concerns, the EAP can help with any issue affecting overall health, well-being and life management.

- Unlimited Telephonic Clinical Assessment and Referral
- Up to 3 Sessions of Professional Assessment for Employees and Family Members
- Unlimited Child Care and Elder Care Referrals
- Legal Consultation for Unlimited Number of Issues Per year
- Financial consultation for Unlimited Number of Issues per Year
- Unlimited Pet Care Consultation
- Unlimited Education Referrals and Resources
- Unlimited Referrals and Resources for any Personal Service
- Unlimited Community-based Resource Referrals
- Online Legal Resource Center
- *Affinity*™ Online Work-Life Website
- MyACI App for Mobile Access
- Multicultural and Multilingual Providers Available Nationwide

Who to Contact for Help

If an employee or immediate family member wishes to connect with a counselor:

- Call 855-RSL-HELP (855-775-4357)
- Visit rsli@acieap.com
- http://rsli.acieap.com

PERKSPOT DISCOUNT PROGRAM

Through our partnership with Cottingham & Butler, we have access to the PerkSpot Employee Discount Program at no cost to you!

This program provides you access to an online marketplace that delivers thousands of discounts for everyday business and personal purchases, leveraging the purchasing power of some of the largest employers in the United States.

Who is PerkSpot?

- Online savings resource for employees
- Headquartered in Chicago, IL
- Founded in 2006
- 750+ clients nationwide
- 15 million members
- 30,000+ discount offers

Website Features

- **Recommended for You:** chosen based on your top interests
- **Featured Offers:** hand-selected to help you stretch your dollars
- **Today's Perk Alters:** today's best limited-time sales
- **Popular Savings:** trending offers
- **Categories:** shop by category
- **Local Discounts**: shop by location

Create Your Account

1. Visit **www.cottinghambutler.perkspot.com**
2. Click "**Create an Account**"
3. Enter your Name, Email, Gender, Zip Code and create a Password
4. Sign up for email updates
    a. **Weekly Perks:** Stay up to date on the best discounts and exclusive offers available to you
    b. **theLOOP:** PerkSpot's weekly resource for how to excel in the 21st century workplace. Providing insights into workplace trends, lifestyle practices, and strategies for success
5. Click "**Register**"
6. Browse discount offers from over 25 categories

Shop for a Variety of Coupons & Deals from these Categories:

- Apparel
- Auto Buying
- Automotive
- Beauty & Fragrance
- Books, Movies, & Music
- Business Perks
- Cell Phones
- Education
- Electronics
- Financial Wellness
- Flowers & Gifts
- Food
- Health & Wellness
- Hobbies & Creative Arts
- Home & Garden
- Home Services
- Insurance & Protection Services
- Jewelry & Watches
- Movie Tickets
- Office & Business
- Pets
- Real Estate & Moving Services
- Sports & Outdoors
- Tickets & Entertainment
- Toys, Kids & Babies
- Travel

Popular Discounted Brands*:

- Avis
- Canon
- Casper
- Columbia
- Dell
- Enterprise
- Holiday Inn
- Home Chef
- HP
- Ray-Ban

**All brands and discounts available are subject to change. For a current listing of discounts and brands offered visit the website at www.cottinghambutler.perkspot.com*

ADDITIONAL BENEFITS

CONTACTS

BENEFIT	HCC CONTACT	EXT.
Paid Time Off	Christie Lewis	x .3609
Direct Deposit	Renee Welch	x. 3438
Use of Library	Karen Graves	x. 3539
Tuition Waivers	Renee Welch	x. 3438
Educational Assistance	Rhonda Perry	x. 3442
Degree Achievement Award	Christie Lewis	x. 3609
YMCA Membership	Christie Lewis	x. 3609
Bookstore Discount	Madonna Keeney	x. 3459
Computer Purchase Program	Andria Cornelius	x. 3424
Sports Season Pass	Jodi Rogers	x. 3415
Theatre Tickets	Bill Buehler	x. 3490

PAID TIME OFF

The following types of paid time off are available for qualifying employees based on the fiscal year or grant year. Amounts are pro-rated based on eligibility date/hire date.

Employee Group	Sick Days Per Year	Vacation Days Per Year	Personal Days Per Year
FT Administrative	12	21	3
FT Classified, Professional	12	10 (0-5 years of service) 15 (6-15 years of service) 20 (16+ years of service)	3
FT Faculty	12, plus 1 day for each month of summer session taught (max. 14 days)	0	4
Adjunct Faculty	12, plus 1 day for each month of summer session taught (max. 14 days)	0	0
PT Classified (32 hours per week)	78 hours	8 (0-5 years of service) 12 (6-15 years of service) 16 (16+ years of service)	0
PT Classified (28-31 hours per week)	72 hours	0	0
PT Classified (20-27 hours per week)	48 hours	0	0

Sick Leave Bank

All employees who receive sick leave benefits may elect to put one day of their accumulated sick days into the Sick Leave Bank to become a member. Members of the Sick Leave Bank may draw from the bank in the event of their own serious health condition that requires absence from work in excess of accumulated sick leave subject to the conditions of the Sick Leave Bank. For complete information concerning the sick leave bank, see Guidelines of the Sick Leave Bank.

Bereavement Leave

All full-time faculty, administrative, classified and professional employees are entitled for paid bereavement of family members. The College will grant one day paid leave for bereavement of extended family: aunt, uncle, cousin, niece or nephew. Three consecutive days paid leave for family including brother or sister-in-law, son or daughter-in-law, mother or father-in-law, grandparent or grandparent-in-law or grandchild. Five consecutive days paid leave for immediate family: spouse or Civil Union partner, child (biological, adopted, foster, step, legal ward, or a child for whom the employee stood in loco parentis), parent, sibling, stepsibling, stepparent.

Paid Holidays

At least 11 holidays are observed. If the holiday falls on a Saturday, it will be observed at Highland Community College on the preceding Friday, and if the Holiday is on a Sunday, it will be observed at Highland Community College on the following Monday. Holidays to be observed are listed in the annual calendar. Where an employee has an assigned weekly work schedule other than Monday through Friday and holiday observed by the College falls on one of the assigned non‐work days, the employee's supervisor will schedule the workday either immediately before or after the holiday to be observed as the holiday for this employee.

Holiday Shutdown

Between Christmas and New Year's holidays, the campus is closed. Full-time staff members will receive paid time off during this period. Full-time faculty and adjunct faculty are paid for the breaks between the fall and spring semester and spring break.

Summer Hours

Pending Board approval, during the summer sessions, the campus is closed on Fridays. Full-time staff work 7:30 a.m. – 5:30 p.m. with a half-hour lunch. Full-time staff are paid for a full 40 hours of work. Variations to the summer schedule may occur with some departments. During summer hours, full-time staff only need to deduct 8 hours (1 day = 8 hours, 2 days = 16 hours, etc.) from their accrual for each day of paid time off taken.

DIRECT DEPOSIT

Highland Community College has established Direct Deposit as the standard method of payment for payroll earnings. By authorizing HCC to initiate credit entries to your account, you will eliminate any delay in receiving your income that can happen with a paper payroll check.

USE OF LIBRARY

Highland Community College offers employees the convenience of using the Clarence Mitchell Library located on the second floor of building M. As a library card holder, you have access to library resources beyond the PrairieCat catalog, you may request interlibrary loan (ILL) of books or articles. Interlibrary loan is a service that enables users to borrow materials owned by libraries beyond PrairieCat, from Illinois libraries or libraries throughout the country.

EDUCATIONAL BENEFITS

Highland Community College has the following opportunities for employees to enhance their ability to achieve to the fullest extent of their capabilities. Such achievement is intended to promote professional and personal development, promote positive work habits and attitudes, raise the level of efficiency and effectiveness of employees, and, as a result, raise the efficiency and effectiveness of the institution.

Tuition Waivers

Providing a tuition waiver for HCC credit courses allows employees to avail themselves of educational opportunities that the College offers. Such a benefit encourages personal and professional growth that can aid employees in performing their roles at the College.

All full-time employees, their spouses, dependent children and dependent grandchildren are eligible for a tuition waiver for credit courses at Highland Community College providing space is available in the classroom. Tuition free credit courses are also available at HCC for regular part-time classified/non-exempt professional employees who regularly work 14 or more hours per week providing space is available in the classroom. Part-time classified/non-exempt professional employees are eligible for tuition free classes after one continuous full year of employment.

Partial tuition coverage is also available to dependents and spouses of regular part-time classified/non-exempt professional employees meeting the eligibility as outlined above as follows: the College will provide half of the tuition coverage for ½ time regular non-exempt professional and classified employees' spouses and dependents and three-quarters of tuition coverage for ¾ time regular non-exempt professional and classified employees' spouses and dependents.

Educational Assistance

After completion of one full year of employment, full-time administrative, professional and classified employees may receive, at an educational institution other than the College and subject to approval of the immediate supervisor, educational assistance from the College at the rate of $350 per semester hour, or the actual tuition cost per semester hour, whichever is less. Educational assistance will be paid upon submission of evidence indicating satisfactory course completion. Total allowable reimbursement shall not exceed $5,000 to any one person during any two-year period starting at the time initial coursework is commenced. Per the Faculty Union Agreement, faculty also qualify for this benefit. For faculty, any salary adjustments because of additional work satisfactorily completed shall be made at the beginning of the next semester following satisfactory course completion.

Degree Achievement Award

Each full-time administrative, professional and classified staff member (not covered by a collective bargaining agreement) will receive a $450 increase in pay the fiscal year after completing an Associate's degree, Bachelor's degree, Master's degree or Doctorate degree. This raise will be in addition to any other increase provided by the College.

This is a one-time bonus or stipend and it will be used in future increase calculations for the employee. A full-time employee will receive the $450 increase for each level of degree earned but only for one degree at each level. It is the responsibility of the employee to inform their supervisor and the Human Resources Office that they intend to pursue a degree and when they complete the degree. A letter and evidence of completion from the employee will be required for verification.

YMCA MEMBERSHIP

Full-time employees are given the opportunity to obtain an individual YMCA membership at reduced cost. Part-time employees are also eligible to receive a membership at a discount. Employees with YMCA membership may option for various additional YMCA programs or family membership.

BOOKSTORE DISCOUNT

All full-time and part-time faculty and staff may purchase textbooks, for use by themselves, their spouse or Civil Union partner, or their dependents (as defined in Policy 4.223) at a discount off retail price equal to the markup (not to exceed 20%).

All full-time and part-time faculty and staff may purchase clothing and gift items at a 20 percent discount. The discount on technology and software products will be determined by the bookstore on an item by item basis. There will be no discounts on the following items: meal cards, computer math software licenses, magazine subscriptions, and transit passes.

COMPUTER PURCHASE PROGRAM

The plan allows all full-time employees who have completed at least twelve months of continuous service as a regular employee, a loan equal to 100% of the purchase price of a personal computer minus $50 down payment. The minimum purchase is $500, maximum purchase is $2,000.

SPORTS AND FINE ARTS EVENTS

All full-time employees may receive free admittance to Highland sports events. Full-time employees may receive free admission for themselves and one guest at most Fine Arts Events.

APPENDIX

IN-NETWORK VS OUT-OF-NETWORK

The Basics

Knowing the difference between an in-network and out-of-network provider can save you a lot of money.

In-network Provider—A provider who is contracted with your health insurance company to provide services to plan members at pre-negotiated rates.

Out-of-network Provider—A provider who is not contracted with your health insurance company.

Getting the Most Out of Your Care

Calling the physician directly and double-checking with your insurance company is the best way to ensure that the provider is in-network.

If you are receiving surgery, make sure to ask if the service is completely in-network. Often times, things such as anesthesia are not covered even though the primary physician is in-network.

Billing & Claim Differences

Because in-network and out-of-network providers are treated differently by your health insurance company, you will be billed differently depending on the type of provider you use for your care.

In-network Bill

Provider	Network	Bill	Insurance Company Payment, Explanation of Benefits	Patient
The patient receives treatment. The doctor then sends the bill to the insurance company.	Appropriate discount for using an in-network provider is applied.	The bill for services is presented to the insurance company. Payment responsibilities are calculated and divided between the patient and the insurance company.	Insurance pays for its portion of the bill from the provider. A summary of charges and insurance payments is sent to the patient via the insurance company.	Patient pays doctor's office for copayments, deductibles and/or coinsurance that he or she is responsible for.

Out-of-network Bill

Provider	Bill	Insurance Company Payment, Explanation of Benefits	Patient
The patient receives treatment. The doctor then sends the bill to the insurance company.	The bill for services is presented to the insurance company. Payment responsibilities are calculated and divided between the patient and the insurance company.	Insurance pays for its portion of the bill from the provider. A summary of charges and insurance payments is sent to the patient via the insurance company.	Patient pays doctor's office for copayments, deductibles and/or coinsurance that he or she is responsible for.

Preventive Care

Preventive care is a type of health care whose purpose is to shift the focus of health care from treating sickness to maintaining wellness and good health. This includes a variety of health care services, such as a physical examination, screenings, laboratory tests, counseling and immunizations.

Preventive care also helps lower the long-term cost of managing disease because it helps catch problems in the early stages when most diseases are more readily treatable. The cost of early treatment or diet or lifestyle changes is less than the cost of treating and managing a full-blown chronic disease or serious illness.

BENEFIT TERMS

The world of health insurance has many terms that can be confusing. Understanding your costs and benefits—and estimating the price of a visit to the doctor—becomes much easier once you are able to make sense of the terminology.

Definitions

- **Annual limit**—Cap on the benefits your insurance company will pay in a given year while you are enrolled in a particular health insurance plan.
- **Claim**—A bill for medical services rendered.
- **Cost-sharing**—Health care provider charges for which a patient is responsible under the terms of a health plan. This includes deductibles, coinsurance and copayments.
- **Coinsurance**—Your share of the costs of a covered health care service calculated as a percentage of the allowed amount for the service.
- **Copayment (copay)**—A fixed amount you pay for a covered health care service, usually when you receive the service.
- **Deductible**—The amount you owe for health care services each year before the insurance company begins to pay. Example: John has a health plan with a $1,000 annual deductible. John falls off his roof and has to have three knee surgeries, the first of which is $800. Because John hasn't paid anything toward his deductible yet this year, and because the $800 surgery doesn't meet the deductible, John is responsible for 100 percent of his first surgery.
- **Dependent Coverage**—Coverage extended to the spouse and children of the primary insured member. Age restrictions on the coverage may apply.
- **Explanation of Benefits (EOB)**—A statement sent from the health insurance company to a member listing services that were billed by a provider, how those charges were processed and the total amount of patient responsibility for the claim.
- **Group Health Plan**—A health insurance plan that provides benefits for employees of a business.
- **In-network Provider**—A provider who is contracted with your health insurance company to provide services to plan members at pre-negotiated rates.
- **Inpatient Care**—Care rendered in a hospital when the duration of the hospital stay is at least 24 hours.
- **Insurer (carrier)**—The insurance company providing coverage.
- **Insured**—The person with the health insurance coverage. For group health insurance, your employer will typically be the policyholder and you will be the insured.
- **Open Enrollment Period**—Time period during which eligible persons may opt to sign up for coverage under a group health plan.
- **Out-of-network Provider**—A provider who is not contracted with your health insurance company.
- **Out-of-pocket Maximum (OOPM)**—The maximum amount you should have to pay for your health care during one year, excluding the monthly premium. After you reach the annual OOPM, your health insurance or plan begins to pay 100 percent of the allowed amount for covered health care services or items for the rest of the year.
- **Outpatient Care**—Care rendered at a medical facility that does not require overnight hospital admittance or a hospital stay lasting 24 hours or more.
- **Policyholder**—The individual or entity that has entered into a contractual relationship with the insurance carrier.
- **Premium**—Amount of money charged by an insurance company for coverage.
- **Preventive Care**—Medical checkups and tests, immunizations and counseling services used to prevent chronic illnesses from occurring.
- **Provider**—A clinic, hospital, doctor, laboratory, health care practitioner or pharmacy.
- **Qualifying Life Event**—A life event designated by the IRS that allows you to amend your current plan or enroll in new health insurance. Common life events include marriage, divorce, and having or adopting a child.
- **Qualified Medical Expense**—Expenses defined by the IRS as the costs attached to the diagnosis, cure, mitigation, treatment or prevention of disease, or for the purpose of affecting any structure or function of the body.
- **Summary of Benefits and Coverage (SBC)**—An easy-to-read outline that lets you compare costs and coverage between health plans.

Acronyms

- **ACA**—Affordable Care Act
- **CDHC**—Consumer driven or consumer directed health care
- **CDHP**—Consumer driven health plan
- **CHIP**—The Children's Health Insurance Program. A program that provides health insurance to low-income children, and in some states, pregnant women who do not qualify for Medicaid but cannot afford to purchase private health insurance.
- **CPT Code**—Current procedural terminology code. A medical code set that is used to report medical, surgical, and diagnostic procedures and services to entities, such as physicians, health insurance companies and accreditation organizations.
- **FPL**—Federal poverty level. A measure of income level issued annually by the Department of Health and Human Services (HHS) and used to determine eligibility for certain programs and benefits.
- **FSA**—Flexible spending account. An employer-sponsored savings account for health care expenses.
- **HDHP**—High deductible health plan
- **HMO**—Health maintenance organization
- **HRA**—Health reimbursement arrangement. An employer-funded arrangement that reimburses employees for certain medical expenses.
- **HSA**—Health savings account. A tax-advantaged savings account that accompanies HDHPs.
- **OOP**—Out-of-pocket limit. The maximum amount you have to pay for covered services in a plan year.
- **PCE**—Pre-existing condition exclusion. A plan provision imposing an exclusion of benefits due to a pre-existing condition.
- **PPO**—Preferred provider organization. A type of health plan that contracts with medical providers (doctors and hospitals) to create a network of participating providers. You pay less when using providers in the plan's network, but can use providers outside the network for an additional cost.
- **QHP**—Qualified health plan. A certified health plan that provides an essential health benefits package. Offered by a licensed health insurer.

ANNUAL REQUIRED NOTICES

Highland Community College
Health Law Notices

Michelle's Law Notice
If there is a medically necessary leave of absence from a post-secondary educational institution or other change in enrollment that: (1) begins while a dependent child is suffering from a serious illness or injury; (2) is certified by a physician as being medically necessary; and (3) causes the dependent child to lose student status for purposes of coverage under the plan, that child may maintain dependent eligibility for up to one year. If the treating physician does not provide written documentation when requested by the Plan Administrator that the serious illness or injury has continued, making the leave of absence medically necessary, the plan will no longer provide continued coverage.

Benefits During Family Medical Leave
Assuming the Plan Administrator meets certain criteria during the preceding calendar year, the Plan will comply with the Family and Medical Leave Act (FMLA) of 1993 as amended, which provides benefit continuation rights during an approved medical leave of absence. If the Plan Administrator is subject to the law, an employee and any dependents covered under a health benefit plan may be eligible to continue the coverage under that plan for a certain period of time.

Any employer contributions made under the terms of the Plan shall continue to be made on behalf of such employee electing to maintain coverage while on FMLA leave. An employee on FMLA leave must make any applicable contributions to maintain coverage. To the extent required under the FMLA and in accordance with procedures established by the Plan Administrator such employee contributions may be payable:

- prior to the employee taking the leave; or
- during the leave; or
- repaid to the employer through payroll deductions upon return to work following the leave.

Contact the Plan Administrator for additional information on the FMLA leave policy or to request leave. Certain rights under specific state family leave laws may also apply.

Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA)
Under USERRA, an employer is required to offer COBRA-like continuation of coverage to covered employees in the uniformed services if their absence from work during military duty would result in a loss of coverage as a result of such active duty. The maximum length of USERRA continuation of coverage is the lesser of 24 months beginning on the date of the employee's departure, or the period beginning on the date of the employee's departure and ending on the date on which the employee failed to return from active duty or apply for reemployment within the time allowed by USERRA. If an employee elects to continue coverage pursuant to USERRA, such employee, and any covered dependents, will be required to pay up to 102% of the full premium for coverage elected. For military leaves of 30 days or less, the employee is not required to contribute more than the amount he or she would have paid as an active employee. Continued coverage under this provision pursuant to USERRA will reduce any coverage continuation provided under COBRA Continuation.

Premium Assistance Under Medicaid and The Children's Health Insurance Program (CHIP) – Applies to Group Health Plans Only
If an Employee or an Employee's children are eligible for Medicaid or CHIP and are eligible for health coverage from an employer, the state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If the Employee or his/her children are not eligible for Medicaid or CHIP, they will not be eligible for these premium assistance programs but they may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit **www.healthcare.gov**.

If an Employee or his/her dependents are already enrolled in Medicaid or CHIP and they live in a State listed below, they may contact State Medicaid or CHIP office to find out if premium assistance is available.

If an Employee or his/her dependents are NOT currently enrolled in Medicaid or CHIP, and they think they (or any of their dependents) might be eligible for either of these programs, they can contact the State Medicaid or CHIP office or dial **1-877-KIDS NOW** or go to **www.insurekidsnow.gov** to find out how to apply. If they qualify, ask if the state has a program that might help pay the premiums for an employer-sponsored plan.
If an Employee or his/her dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under their employer plan, the employer must allow the Employee to enroll in the employer plan if they are not already enrolled. This is called a "special enrollment" opportunity, and **the Employee must request coverage within 60 days of being determined eligible for premium assistance.** If the Employee has questions about enrolling in the employer's plan, contact the Department of Labor at **www.askebsa.dol.gov** or call **1-866-444-EBSA (3272).**

Employees living in one of the following States, may be eligible for assistance paying employer health plan premiums. The following list of States is current as of January 31, 2019. Contact the respective State for more information on eligibility –

ALABAMA – Medicaid
Website: http://myalhipp.com/
Phone: 1-855-692-5447
ALASKA – Medicaid
The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/
Phone: 1-866-251-4861
Email: CustomerService@MyAKHIPP.com
Medicaid Eligibility:
http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx
ARKANSAS – Medicaid
Website: http://myarhipp.com/
Phone: 1-855-MyARHIPP (855-692-7447)
FLORIDA – Medicaid
Website: http://flmedicaidtplrecovery.com/hipp/
Phone: 1-877-357-3268
GEORGIA – Medicaid
Website: www.medicaid.georgia.gov
- Click on Health Insurance Premium Payment (HIPP)
Phone: 404-656-4507
INDIANA – Medicaid
Healthy Indiana Plan for low-income adults 19-64
Website: http://www.in.gov/fssa/hip/
Phone: 1-877-438-4479
All other Medicaid
Website: http://www.indianamedicaid.com
Phone: 1-800-403-0864
IOWA – Medicaid
Website: http://dhs.iowa.gov/hawk-i
Phone: 1-800-257-8563
KANSAS – Medicaid
Website: http://www.kdheks.gov/hcf/
Phone: 1-785-296-3512
KENTUCKY– Medicaid
Website: https://chfs.ky.gov
Phone: 1-800-635-2570
LOUISIANA – Medicaid
Website:
http://dhh.louisiana.gov/index.cfm/subhome/1/n/331
Phone: 1-888-695-2447
MAINE – Medicaid
Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html
Phone: 1-800-442-6003
TTY: Maine relay 711
MASSACHUSETTS – Medicaid and CHIP
Website:
http://www.mass.gov/eohhs/gov/departments/masshealth/
Phone: 1-800-862-4840
MINNESOTA – Medicaid
Website: https://mn.gov/dhs/people-we-serve/seniors/health-care/health-care-programs/programs-and-services/other-insurance.jsp
Phone: 1-800-657-3739 or 651-431-2670
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

NEBRASKA – Medicaid
Website: http://www.ACCESSNebraska.ne.gov
Phone: (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/oii/hipp.htm
Phone: 603-271-5218
Toll-Free: 1-800-852-3345, ext. 5218
NEW JERSEY – Medicaid and CHIP
Medicaid Website:
http://www.state.nj.us/humanservices/dmahs/clients/medicaid/
Medicaid Phone: 609-631-2392
CHIP Website:
http://www.njfamilycare.org/index.html
CHIP Phone: 1-800-701-0710
NEW YORK – Medicaid
Website:
https://www.health.ny.gov/health_care/medicaid/
Phone: 1-800-541-2831
NORTH CAROLINA – Medicaid
Website: https://dma.ncdhhs.gov/
Phone: 919-855-4100
NORTH DAKOTA – Medicaid
Website:
http://www.nd.gov/dhs/services/medicalserv/medicaid/
Phone: 1-844-854-4825
OKLAHOMA – Medicaid and CHIP
Website: http://www.insureoklahoma.org
Phone: 1-888-365-3742
OREGON – Medicaid and CHIP
Website:
http://healthcare.oregon.gov/Pages/index.aspx
http://www.oregonhealthcare.gov/index-es.html
Phone: 1-800-699-9075
PENNSYLVANIA – Medicaid
Website:
http://www.dhs.pa.gov/provider/medicalassistance/healthinsurancepremiumpaymenthippprogram/index.htm
Phone: 1-800-692-7462
RHODE ISLAND – Medicaid
Website: http://www.eohhs.ri.gov/
Phone: 855-697-4347
SOUTH CAROLINA – Medicaid
Website: https://www.scdhhs.gov
Phone: 1-888-549-0820
SOUTH DAKOTA – Medicaid
Website: http://dss.sd.gov
Phone: 1-888-828-0059

TEXAS – Medicaid
Website: http://gethipptexas.com/
Phone: 1-800-440-0493
UTAH – Medicaid and CHIP
Medicaid Website: https://medicaid.utah.gov/
CHIP Website: http://health.utah.gov/chip
Phone: 1-877-543-7669
VERMONT – Medicaid
Website: http://www.greenmountaincare.org/
Phone: 1-800-250-8427

VIRGINIA – Medicaid and CHIP
Medicaid Website:
http://www.coverva.org/programs_premium_assistance.cfm
Medicaid Phone: 1-800-432-5924
CHIP Website:
http://www.coverva.org/programs_premium_assistance.cfm
CHIP Phone: 1-855-242-8282
WASHINGTON – Medicaid
Website: http://www.hca.wa.gov/free-or-low-cost-health-care/program-administration/premium-payment-program
Phone: 1-800-562-3022 ext. 15473
WEST VIRGINIA – Medicaid
Website: http://mywvhipp.com/
Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
WISCONSIN – Medicaid and CHIP
Website:
https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf
Phone: 1-800-362-3002
WYOMING – Medicaid
Website:
https://health.wyo.gov/healthcarefin/medicaid/
Phone: 307-777-7531
To see if any other States have added a premium assistance program since January 31, 2019, 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

Important Disclosures

Women's Health and Cancer Rights Act of 1998
The Federal Women's Health and Cancer Rights Act of 1998 requires coverage of treatment related to mastectomy. If the participant is eligible for mastectomy benefits under health coverage and elects breast reconstruction in connection with such mastectomy, she is also covered for the following:

a. Reconstruction of the breast on which mastectomy has been performed;
b. Surgery and reconstruction of the other breast to produce a symmetrical appearance;
c. Prostheses;
d. Treatment of physical complications of all states of mastectomy, including lymphademas.

Coverage for reconstructive breast surgery may not be denied or reduced on the ground that it is cosmetic in nature or that it otherwise does not meet the coverage definition of "medically necessary." Benefits will be provided on the same basis as for any other illness or injury under the Plan. Coverage for breast reconstruction and related services will be subject to applicable deductibles, co-payments and coinsurance amounts that are consistent with those that apply to other benefits under the Plan.

Maternity Coverage Length of Hospital Stay
Group health plans and health insurance issuers offering group health insurance coverage 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 normal 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 or 96 hours, as applicable. Additionally, no group health plan or issuer may 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).

Medical Child Support Orders
A Component Benefit Plan must recognize certain legal documents presented to the Plan Administrator by participants or their representatives. The Plan Administrator may be presented court orders which require child support, including health benefit coverage. The Plan Sponsor must recognize a Qualified Medical Child Support Order (QMCSO), within the meaning of ERISA section 609(a)(2)(B), under any Component Benefit Plan providing health benefit coverage.

A QMCSO is a state court or administrative agency order that requires an employer's medical plan to provide benefits to the child of an employee who is covered, or eligible for coverage, under the employer's plan. QMCSOs usually apply to a child who is born out of wedlock or whose parents are divorced. If a QMCSO applies, the employee must pay for the child's medical coverage and will be required to join the Plan if not already enrolled. The Plan Administrator, when receiving a QMCSO, must promptly notify the employee and the child that the order has been received and what procedures will be used to determine if the order is "qualified." If the Plan Administrator determines the order is qualified and the employee must provide coverage for the child pursuant to the QMCSO, contributions for such coverage will be deducted from the employee's paycheck in an amount necessary to pay for such coverage. The affected employee will be notified once it is determined the order is qualified. Participants and beneficiaries can obtain a copy of the procedure governing QMCSO determinations from the Plan Administrator without charge.

New Health Insurance Marketplace Coverage Options and Your Health Coverage

PART A: General Information
When key parts of the health care law took effect in 2014, a new way to buy health insurance became available: the Health Insurance Marketplace. To assist Employees as they evaluate options for themselves and their family, this notice provides some basic information about the new Marketplace and employment-based health coverage offered by their employer.

What is the Health Insurance Marketplace?
The Marketplace is designed to help individuals and families find health insurance that meets their needs and fits their budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. Employees may also be eligible for a new kind of tax credit that

lowers their monthly premium right away. The open enrollment period for health insurance coverage through the Marketplace began on Nov. 1st, and ended on Dec. 15th. Individuals must have enrolled or changed plans prior to Dec. 15th, for coverage starting as early as Jan. 1st. After Dec. 15th, individuals can get coverage through the Marketplace only if they qualify for a special enrollment period.

Can individuals Save Money on Health Insurance Premiums in the Marketplace?
Individuals may qualify to save money and lower monthly premiums, but only if their employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on premiums depends on household income.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?
Yes. If the Employee has an offer of health coverage from his/her employer that meets certain standards, they will not be eligible for a tax credit through the Marketplace and may wish to enroll in their employer's health plan. However, an individual may be eligible for a tax credit that lowers their monthly premium, or a reduction in certain cost-sharing if their employer does not offer coverage at all or does not offer coverage that meets certain standards. If the cost of a plan from an employer that would cover the Employee (and not any other members of their family) is more than 9.56% of household income for the year, or if the coverage the employer provides does not meet the "minimum value" standard set by the Affordable Care Act, the Employee may be eligible for a tax credit. *

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

How Can Individuals Get More Information?
For more information about coverage offered by the Employer, please check the summary plan description or contact Human Resources.

The Marketplace can help when evaluating coverage options, including 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 the area.

*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% of such costs.

Special Enrollment Periods

Special Enrollment Rights – If an employee declines enrollment for him/herself or for their dependents (including their spouse) because of other health insurance coverage, they may be able to enroll him/herself or their dependents in this Plan in the future, provided they request enrollment within 30 days after their other coverage ends. Coverage will begin under this Plan on the first day of the month after the Plan receives the enrollment form.
If an employee acquires a new dependent as a result of marriage, birth, adoption, or placement for adoption, they may be able to enroll him/herself and their dependents provided that they request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption. If an employee adds coverage under these circumstances, they may add coverage mid-year. Coverage will become effective retroactive to the date of the marriage, birth, adoption, or placement for adoption. The plan does not permit mid-year additions of coverage except for newly eligible persons and special enrollees.

Individuals gaining or losing Medicaid or State Child Health Insurance Coverage (SCHIP) – If an employee or their dependent was:

1. covered under Medicaid or a state child health insurance program and that coverage terminated due to loss of eligibility, or
2. becomes eligible for premium assistance under Medicaid or state child health insurance program, a special enrollment period under this Plan will apply. The employee must request coverage under this Plan within 60 days after the termination of such Medicaid or SCHIP, or within 60 days of becoming eligible for the premium assistance from Medicaid or the SCHIP. Coverage under the plan will become effective on the date of termination of eligibility for Medicaid/state child health insurance program, or the date of eligibility for premium assistance under Medicaid or SCHIP.

HIPAA Notice of Privacy Practices Effective Date: March 1, 2013

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

HIPAA Notice of Privacy Practices

The Highland Community College Group Health Plan (the "Plan"), which includes medical, dental, vision and flexible spending account coverages offered under the Highland Community College Plans, are required by law (under the Administrative Simplification provision of the Health Insurance Portability and Accountability Act of 1996 HIPAA's privacy rule) to take reasonable steps to ensure the privacy of personally identifiable health information. This Notice is being provided to inform employees (and any of their dependents) of the policies and procedures Highland Community College has implemented and their rights under them, as well as under HIPAA. These policies are meant to prevent any unnecessary disclosure of individual health information.

Use and Disclosure of individually identifiable Health Information by the Plan that Does Not Require the Individual's Authorization. The plan may use or disclose health information (that is protected health information (PHI), as defined by HIPAA's privacy rule) for:

1. Payment and Health Care Operations: In order to make coverage determinations and payment (including, but not limited to, billing, claims management, subrogation, and plan reimbursement). For example, the Plan may provide information regarding an individual's coverage or health care treatment to other health plans to coordinate payment of benefits. Health information may also be used or disclosed to carry out Plan operations, such as the administration of the Plan and to provide coverage and services to the Plan's participants. For example, the Plan may use health information to project future benefit costs, to determine premiums, conduct or arrange for case management or medical review, for internal grievances, for auditing purposes, business planning and management activities such as planning related analysis, or to contract for stop-loss coverage. Pursuant to the Genetic Information Non-Discrimination Act (GINA), the Plan does not use or

disclose genetic information for underwriting purposes.

2. Disclosure to the Plan Sponsor: As required, in order to administer benefits under the Plan. The Plan may also provide health information to the plan sponsor to allow the plan sponsor to solicit premium bids from health insurers, to modify the Plan, or to amend the Plan.

3. Requirements of Law: When required to do so by any federal, state or local law.

4. Health Oversight Activities: To a health oversight agency for activities such as audits, investigations, inspections, licensure, and other proceedings related to the oversight of the health plan.

5. Threats to Health or Safety: As required by law, to public health authorities if the Plan, in good faith, believes the disclosure is necessary to prevent or lessen a serious or imminent threat to an individual's health or safety or to the health and safety of the public.

6. Judicial and Administrative Proceedings: In the course of any administrative or judicial proceeding in response to an order from a court or administrative tribunal, in response to a subpoena, discovery request or other similar process. The Plan will make a good faith attempt to provide written notice to the individual to allow them to raise an objection.

7. Law Enforcement Purposes: To a law enforcement official for certain enforcement purposes, including, but not limited to, the purpose of identifying or locating a suspect, fugitive, material witness or missing person.

8. Coroners, Medical Examiners, or Funeral Directors: For the purpose of identifying a deceased person, determining a cause of death or other duties as authorized by law.

9. Organ or Tissue Donation: If the person is an organ or tissue donor, for purposes related to that donation.

10. Specified Government Functions: For military, national security and intelligence activities, protective services, and correctional institutions and inmates.

11. Workers' Compensation: As necessary to comply with workers' compensation or other similar programs.

12. Distribution of Health-Related Benefits and Services: To provide information to the individual on health-related benefits and services that may be of interest to them.

Notice in Case of Breach

Highland Community College is required to maintain the privacy of PHI; to provide individuals with this notice of the Plan's legal duties and privacy practices with respect to PHI; and to notify individuals of any breach of their PHI.

Use and Disclosure of Individual Health Information by the Plan that Does Require Individual Authorization: Other than as listed above, the Plan will not use or disclose without your written authorization. You may revoke your authorization in writing at any time, and the Plan will no longer be able to use or disclose the health information. However, the Plan will not be able to take back any disclosures already made in accordance with the Authorization prior to its revocation. The following uses and disclosures will be made only with authorization from the individual: (i) most uses and disclosures of psychotherapy notes (if recorded by a covered entity); (ii) uses and disclosures of PHI for marketing purposes, including subsidized treatment communications; (iii) disclosures that constitute a sale of PHI; and (iv) other uses and disclosures not described in this notice.

Individual Rights with Respect to Personal Health Information: Each individual has the following rights under the Plan's policies and procedures, and as required by HIPAA's privacy rule:

Right to Request Restrictions on Uses and Disclosures: An individual may request the Plan to restrict uses and disclosures of their health information. The Plan will accommodate reasonable requests; however, it is not required to agree to the request, unless it is for services paid completely by the individual out of their own pocket. A wish to request a restriction must be sent in writing to HIPAA Privacy Officer, at Highland Community College, 2998 W Pearl City Rd. Freeport, Illinois 61032, (815)235-6130.

Right to Inspect and Copy Individual Health Information: An individual may inspect and obtain a copy of their individual health information maintained by the Plan. The requested information will be provided within 30 days if the information is maintained on site or within 60 days if the information is maintained offsite. A single 30-day extension is allowed if the Plan is unable to comply with the deadline. A written request must be provided to HIPAA Privacy Officer at Highland Community College, 2998 W Pearl City Rd. Freeport, Illinois 61032, (815)235-6130. If the individual requests a copy of their health information, the Plan may charge a reasonable fee for copying, assembling costs and postage, if applicable, associated with their request.

Right to Amend Your Health Information: You may request the Plan to amend your health information if you feel that it is

incorrect or incomplete. The Plan has 60 days after the request is made to make the amendment. A single 30-day extension is allowed if the Plan is unable to comply with this deadline. A written request must be provided to HIPAA Privacy Officer, at Highland Community College, 2998 W Pearl City Rd. Freeport, Illinois 61032, (815)235-6130. The request may be denied in whole or part and if so, the Plan will provide a written explanation of the denial.

Right to an Accounting of Disclosures: An individual may request a list of disclosures made by the Plan of their health information during the six years prior to their request (or for a specified shorter period of time). However, the list will not include disclosures made: (1) to carry out treatment, payment or health care operations; (2) disclosures made prior to April 14, 2004; (3) to individuals about their own health information; and (4) disclosures for which the individual provided a valid authorization. A request for an accounting form must be used to make the request and can be obtained by contacting the HIPAA Privacy Officer at Highland Community College, 2998 W Pearl City Rd. Freeport, Illinois 61032, (815)235-6130. The accounting will be provided within 60 days from the submission of the request form. An additional 30 days is allowed if this deadline cannot be met.

Right to Receive Confidential Communications: An individual may request that the Plan communicate with them about their health information in a certain way or at a certain location if they feel the disclosure could endanger them. The individual must provide the request in writing to the HIPAA Privacy Officer at Highland Community College, 2998 W Pearl City Rd. Freeport, Illinois 61032, (815)235-6130. The Plan will attempt to honor all reasonable requests.

Right to a Paper Copy of this Notice: Individuals may request a paper copy of this Notice at any time, even if they have agreed to receive this Notice electronically. They must contact their HIPAA Privacy Officer at Highland Community College, 2998 W Pearl City Rd. Freeport, Illinois 61032, (815)235-6130 to make this request.

The Plan's Duties: The Plan is required by law to maintain the privacy of individual health information as related in this Notice and to provide this Notice of its duties and privacy practices. The Plan is required to abide by the terms of this Notice, which may be amended from time to time. The Plan reserves the right to change the terms of this Notice and to make the new Notice provisions effective for all health information that it maintains.

Complaints and Contact Person: If an individual wishes to exercise their rights under this Notice, communicate with the Plan about its privacy policies and procedures, or file a complaint with the Plan, they must contact the HIPAA Contact Person, at Highland Community College, 2998 W Pearl City Rd. Freeport, Illinois 61032, (815)235-6130. They may also file a complaint with the Secretary of Health and Human Services if they believe their privacy rights have been violated.

Important Notice from Highland Community College About Your Prescription Drug Coverage and Medicare (Creditable Coverage)

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Highland Community College 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. Highland Community College has determined that the prescription drug coverage offered by the Highland Community College 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 Highland Community College coverage will not be affected.
If you do decide to join a Medicare drug plan and drop your current Highland Community College coverage, be aware that you and your dependents will 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 Highland Community College and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.
If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For More Information About This Notice Or Your Current Prescription Drug Coverage
Contact the person listed below for further information. **NOTE:** You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through Highland Community College 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: 04/11/2019
Name of Entity/Sender: Highland Community College
Contact--Position/Office: Human Resources
Address: 2998 W Pearl City Rd. Freeport, Illinois 61032
Phone Number: (815)235-6130