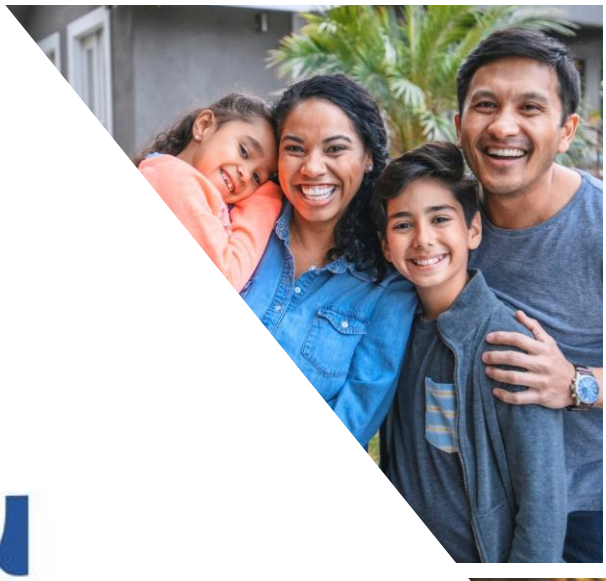


HIGHLAND COMMUNITY COLLEGE

2025-2026 | All Employees

Benefits Guide

Your Benefits, Your Choice

Inside

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.

Welcome

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 College.

New Employees

Right now is your chance to elect the coverage you want for yourself and your family for July 1, 2025 – June 30, 2026. 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. Examples include:

- Marriage, divorce, legal separation, or death of a spouse
- Birth, adoption, or death of a child
- Change in child's dependent status
- Change in residence
- Change in employment status or a change in coverage under another employer-sponsored plan

Medicare Part D Notice:

If you or your dependents are on Medicare or will be eligible within 12 months, federal law offers more prescription drug coverage options. Refer to page **39** for details.

What's Changed?

Benefit Highlights

Benefit changes take effect on **07/01/2025**.

Protect Your **Health**

- **Medical:** Small increase in employee contributions, and new HRA plan design on the traditional and co-pay plans!
- **Dental:** No increase in employee contributions

Protect Your **Family**

- **New this year: Voluntary Short Term Disability!**
  - Provides income replacement in the event of an injury or illness.

Protect Your **Wallet**

- **New this year: Hospital Indemnity Benefit!**
  - Get cash benefits for non-work-related hospital stays including routine pregnancy. This plan includes a $50 wellness benefit that pays you for completing annual health screenings.

How to Enroll: Action Required!

To ensure you are covered appropriately, everyone is required to complete open enrollment between **May 16 and June 02, 2025**.

Enroll online through ADP!

Scan QR code or visit
login.adp.com/welcome

Need Help?

Contact Christie Lewis

Human Resources Manager, ext. 3609

Contacts

Highland Community College Benefits Contact		
Karen Brown	815-599-3402	karen.brown@highland.edu
Stephanie Hintz	815-599-3534	stephanie.hintz@highland.edu

Coverage	Carrier	Phone Number	Website/Email
Medical Insurance	BCBS of IL	800-541-2768	www.bcbsil.com
Mail Order Pharmacy	Express Scripts®	833-715-0942	www.express-scripts.com/rx
Health Reimbursement Arrangement	Flex®	888-345-7990	www.myflexaccount.com
Virtual Care	MDLive	800-676-4204	www.MDLIVE.com/bcbsil
Family Advantage Health Plan	BCC	800-685-6100	www.benxcel.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	Flex®	888-345-7990	www.myflexaccount.com
Life Insurance	BCBS/Dearborn National	844-323-8302	dearbornnational.com
Disability Insurance	BCBS/Dearborn National	844-323-8302	dearbornnational.com
	State University Retirement System (SURS)	800-275-7877	www.surs.org
Critical Illness Insurance	BCBS/Dearborn National	844-323-8302	dearbornnational.com
Accident Insurance	BCBS/Dearborn National	844-323-8302	dearbornnational.com
Hospital Insurance	BCBS/Dearborn National	844-323-8302	dearbornnational.com
Employee Assistance Program	ComPsych® GuidanceResources®	888-628-4844	guidanceresources.com

Employee Contributions

The following tables include employee contributions per pay period (26 weeks). If you have questions or concerns, please speak with Human Resources.

Medical*	Traditional Plan	HDHP (HSA Qualified) Plan	Copay Plan
Employee Only	$94.92	$77.34	$80.98
Family	$237.30	$193.35	$202.45

*Those who elect to waive the medical plan will receive a $3,600 annual benefit (spread out over the 26 pay periods).

Dental	
Employee Only	$2.95
Employee + Spouse	$6.00
Employee + Child(ren)	$6.19
Family	$11.06

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

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.
- **Short and 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.

* **IMPORTANT:** 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"

Medical, Dental, and Vision Coverage dependents include:

- 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 of 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.

Medical

BCBS IL

Locate an in-network provider near you at www.bcbsil.com/ or call 800-541-2768

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.

When you enroll in the copay plan option, Highland Community College will contribute a one-time deposit of up to $600 to your Flexible Spending Account (FSA) – this will not decrease the amount you are allowed to contribute to your FSA. Highland's contribution is based on how much you contribute. Highland will match up to $500, regardless of whether or not you contribute to the FSA yourself. Above $500, Highland will only make a dollar-for-dollar match to your contribution, capped at $600.

Prescriptions are not included in the HRA plan.

Medical HRA Options	Traditional Plan		Copay Plan	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Annual Deductible Individual Family	**$1,000** *($5,000 before HRA)* **$2,000** *($15,000 before HRA)*	**$2,000** *($10,000 before HRA)* **$4,000** *($30,000 before HRA)*	**$2,000** *($5,000 before HRA)* **$4,000** *($15,000 before HRA)*	**$4,000** *($10,000 before HRA)* **$8,000** *($30,000 before HRA)*
Coinsurance (Plan Pays/You Pay)	80% / 20%	60% / 40%	80% / 20%	60% / 40%
Annual Out-of-Pocket Maximum Individual Family	**$3,000** *($6,000 before HRA)* **$6,000** *($12,000 before HRA)*	**$6,000** *($12,000 before HRA)* **$12,000** *($24,000 before HRA)*	**$4,000** *($6,000 before HRA)* **$8,000** *($12,000 before HRA)*	**$8,000** *($12,000 before HRA)* **$16,000** *($24,000 before HRA)*
Services	In-Network	Out-of-Network	In-Network	Out-of-Network
Preventive Care	100% Covered	40% after deductible	100% Covered	40% after deductible
Office Visits, Urgent Care, Labs & X-rays	20% after deductible	40% after deductible	$20 copay	40% after deductible
Major Imaging (CT, MRI, PET)			20% after deductible	
Emergency Room	20% after deductible	20% after deductible	20% after deductible	20% after deductible
Prescription Drugs	In-Network	Out-of-Network	In-Network	Out-of-Network
Out-of-Pocket Maximum	$500 Individual / $1,000 Family		N/A	
Generic	$10 Copay		$10 Copay	
Preferred Brand	$35 Copay		$35 Copay	
Non-Preferred Brand	$60 Copay		$60 Copay	
Specialty	$150 Copay	Not Covered	$150 Copay	Not Covered

Please review the full plan documents for details. If the benefits described herein conflict in any way with the Summary Plan Description, the Summary Plan Description will prevail.

*Highland Health Plans comply with the IL Consumer Coverage Disclosure Act (Public Act 102-0630) and offer coverage for all the required Essential Health Benefits. Please see HR portal for disclosure document.

Medical HDHP

Locate an in-network provider near you at www.bcbsil.com/ or call 800-541-2768

BCBS IL

When you enroll in the HDHP (HSA Qualified Plan) Highland Community College will contribute a one-time deposit of $600 to your Health Savings Account (HSA) – this **will** decrease the amount you are allowed to contribute to your HSA.

Medical	HDHP (HSA Qualified) Plan	
	In-Network	Out-of-Network
Annual Deductible Individual Family	 $1,650 $3,300	 $1,650 $3,300
Coinsurance (Plan Pays/You Pay)	100% / 0%	80% / 20%
Annual Out-of-Pocket Maximum Individual Family	 $3,000 $6,000	 $3,000 $6,000
Services	In-Network	Out-of-Network
Preventive Care	100% Covered	20% after deductible
Office Visits, Urgent Care, Labs & X-rays	100% covered after deductible	20% after deductible
Major Imaging (CT, MRI, PET)		
Emergency Room	10% after deductible	10% after deductible
Prescription Drugs	In-Network	Out-of-Network
Out-of-Pocket Maximum	NA	
Generic	20% after deductible	
Preferred Brand	20% after deductible	
Non-Preferred Brand	20% after deductible	
Specialty	20% after deductible	

Please review the full plan documents for details. If the benefits described herein conflict in any way with the Summary Plan Description, the Summary Plan Description will prevail.
*Highland Health Plans comply with the IL Consumer Coverage Disclosure Act (Public Act 102-0630) and offer coverage for all the required Essential Health Benefits. Please see HR portal for disclosure document.

HRA Claim Process

BCBS IL & Flex®

In order for HCC to keep costs competitive, we have a partially self-funded component with BCBS IL. The partially self-funded program is with Flex® who administers our buy-down plan's billing and claims.

What does that mean?

HCC pays for a higher deductible plan from BCBS IL ("Company Plan") but offers you a lower deductible plan ("Employee Plan"). This new plan is lower in cost to you than other comparable plans available through BCBS IL. To utilize a partially self-funded plan, we have contracted with a Third-Party Administrator named Flex.

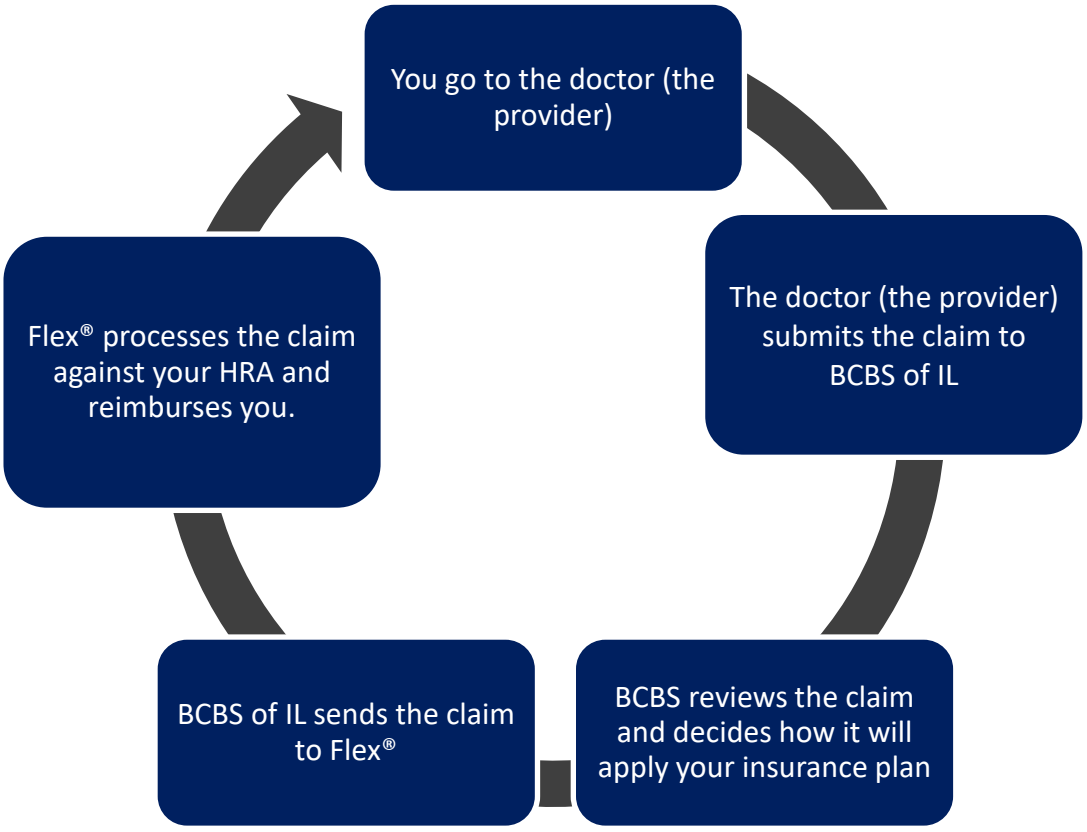
When you visit a health care provider, your claims will be filed with BCBS IL. BCBS IL will process your claim under the "Company Plan". ***If you have an FSA with Flex, funds will first be pulled from your FSA account before the bill for the remaining amount is sent to you.***

What if my provider needs proof that I have an HRA?

Have your provider call Flex® at: 888-345-7990

Check your remaining deductible and/or out-of-pocket maximum balances at www.myflexaccount.com

Please direct other questions to BCBS IL at BCBSIL.com or 877-860-2837



Medical Member Resources

Blue Access for Members (BAM) through BCBS of IL

Blue Access for Members℠

Get all the advantages your health plan offers

Get information about your health benefits, anytime, anywhere. Use your computer, phone or tablet to access the Blue Cross and Blue Shield of Illinois (BCBSIL) secure member website Blue Access for Members (BAM).

With BAM, you can:

- Check the status or history of a claim
- View or print Explanation of Benefits statements
- Locate a doctor or hospital in your plan's network
- Find Spanish-speaking providers
- Request a new ID card – or print a temporary one
- Visit Health Care School to see articles and videos to help you make the most of your benefits

Blue Access Mobile℠

Blue Access Mobile brings convenient, secure access to your mobile phone.

From your mobile phone web browser, you can:

- Register or log in to your secure member site – Blue Access for Members℠ – to view coverage details, access or request identification (ID) cards, check claims status, manage your user profile, use the Message Center and view health and wellness information
- Find a doctor, hospital or urgent care facility
- Access Health Care Reform and Health Care 101 to view general health insurance information and terminology
- Shop for insurance and get a quote before applying
- Locate Blue Cross and Blue Shield of Illinois (BCBSIL) contact information

It is easy to experience Blue Access Mobile.

Simply go to www.bcbsil.com from your mobile phone Web browser. There is no registration required to access the mobile site. However, BCBSIL members must enter their user name and password to log in to Blue Access for Members.

It's easy to get started!

- Go to www.bcbsil.com/member
- Click Register Now
- Use the information on your BCBSIL ID card to complete the registration process.

Text* BCBSILAPP to 33533 to get the BCBSIL app that lets you use BAM while you're on the go. Or visit www.bcbsil.com/mobile for more information.

*Message and data rates may apply

ID Theft Protection Services

BCBS makes available at no additional cost to your identity theft protection services, including credit monitoring, fraud detection, credit/identity repair and insurance to help protect your information. These identity theft protection services are currently provided by BCBS's designated outside vendor and acceptance or declination of these services is optional to you.

If you wish to accept such identity theft protection services, you will need to individually enroll in the program online at www.bcbsil.com or telephonically by calling the toll-free telephone number on your identification card.

*Services may automatically end if you no longer meet the definition of an Eligible Person. Services may change or be discontinued at any time with or without notice and BCBS does not guarantee that a particular vendor or service will be available at any given time. The services are provided as a convenience and are not considered covered benefits under this Certificate.

Mail Order Pharmacy

Express Scripts®

Medicines may take **up to 5 business days** to deliver after Express Scripts® Pharmacy receives and verifies your order.

Express Scripts® Pharmacy delivers your long-term (or maintenance) medicines right where you want them. No driving to the pharmacy. No waiting in line for your prescriptions to be filled.

Savings and Convenience

- Express Scripts® Pharmacy delivers up to a 90-day supply of long-term medicines.[1]
- Prescriptions are delivered to the address of your choice, within the U.S., with free standard shipping.
- You can order from the comfort of your home — through your mobile device, online or over the phone. Your doctor can fax, call or send your prescription electronically to Express Scripts® Pharmacy.
- Tamper-evident, unmarked packaging protects your privacy.

Support and Service

- You can receive notices by phone, email or text — your choice — when your orders are placed and shipped. You will be contacted, if needed, to complete your order. To select your notice preference, register online at **express-scripts.com/rx** or call **833-715-0942**.
- 24/7 access to a team of knowledgeable pharmacists and support staff.
- Choose to receive refill reminder notices by phone or email.
- Multiple pharmacy locations are located across the U.S., for fast processing and dispensing.

Getting Started

Online and Mobile

You have more than one option to fill or refill a prescription online or from a mobile device:

- Visit **express-scripts.com/rx**. Follow the instructions to register and create a profile. See your active prescriptions and/or send your refill order.
- Log in to **myprime.com** and follow the links to Express Scripts® Pharmacy.

Over the Phone

Call **833-715-0942**, 24/7, to refill, transfer a current prescription or get started with mail order. Please have your member ID card, prescription information and your doctor's contact information ready.

Through the Mail

To send a prescription order through the mail, visit **bcbsil.com** and log in to Blue Access for Members℠ (BAM℠). Complete the mail order form. Mail your prescription, completed order form and payment to Express Scripts® Pharmacy.

Talk to Your Doctor

Ask your doctor for a prescription for up to a 90-day supply of each of your long-term medicines.[1] You can ask your doctor to send your prescription electronically to Express Scripts® Pharmacy, call **888-327-9791** for faxing instructions or call the pharmacy at **833-715-0942**. If you need to start your medicine right away, request a prescription for up to a one-month supply you can fill at a local retail pharmacy.

Refills Are Easy

Refill dates are shown on each prescription label. You can choose to have Express Scripts® Pharmacy remind you by phone or email when a refill is due. Choose the reminder option that best suits you.

Questions?

Visit **bcbsil.com**. Or call the phone number listed on your member ID card.

1. Prescriptions of up to a 90-day supply, or the most amount allowed by the benefit plan.

Express Scripts® Pharmacy is a pharmacy that is contracted to provide mail pharmacy services to members of Illinois. The relationship between Express Scripts® Pharmacy and Blue Cross and Blue Shield of Illinois is that of independent contractors. Express Scripts® Pharmacy is a trademark of Express Scripts Strategic Development, Inc.

Prime Therapeutics LLC is a pharmacy benefit management company, contracted by BCBSIL to provide pharmacy benefit management and related other services. BCBSIL, as well as several independent Blue Cross and Blue Shield Plans, has an ownership interest in Prime Therapeutics LLC. MyPrime.com is an online resource offered by Prime Therapeutics, LLC.

Blue Cross and Blue Shield of Illinois, a Division of Health Care Service Corporation, a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association 23128.0521

Family Advantage Health Plan

BCC

Plan Benefits

There are several benefits of the FAHP:

- Reimbursement of any copays, deductibles, and coinsurance due on primary health insurance plan, up to the annual out-of-pocket maximums allowed by the Affordable Care Act. Effectively, this creates a **100% coverage plan** for most participants enrolled in the FAHP.
- No premium contribution deducted from employee's paycheck to enroll in the FAHP.
- Ongoing monthly payroll bonus of $50 per member enrolled in FAHP to help offset any additional premium costs of alternative employer coverage.

Eligibility Criteria

To be eligible, the member[1] (e.g. employee, spouse, and/or child) must meet two criteria:

1. Member has been enrolled on the company medical plan for at least 12 months prior to the FAHP effective date.[2]
2. Member has access to enroll in alternative employer-sponsored medical plan (e.g. via spouse, parent, 2nd job, etc.).

[1] Each member is individually eligible for the plan if they meet the eligibility criteria (i.e. spouse and children can enroll without employee).

[2] New employees must satisfy eligibility requirements, which will be evaluated annually at FAHP open enrollment.

IRS Rules

If eligible for the FAHP, it is important that you comply with IRS rules:

1. You may be enrolled in a Health Reimbursement Account (HRA) or Flexible Spending Account (FSA). However, you cannot be reimbursed from both the FAHP and your HRA or FSA.
2. Employees are not eligible for the FAHP if their alternate coverage:
    - has an active contribution to a Health Savings Account (HSA) – you can deny these contributions and then participate in FAHP; or
    - is Medicare, Medicaid, Tricare, an Individual Policy, a Limited Benefit Health Plan, or any non-employer-sponsored insurance.

How to Enroll

If you are interested in the FAHP, here is what to do next:

1. Verify eligibility for the FAHP with your HR department.
2. Evaluate current coverage vs combination of other employer alternative coverage + FAHP. Use BCC Cost Comparison worksheet.
3. Enroll applicable members in alternative employer coverage. Ensure no HSA dollars are received or contributed if the alternative employer coverage is an HDHP.
4. Waive coverage on HIGHLAND COMMUNITY COLLEGE medical plans for next year and complete the FAHP enrollment and attestation forms.

When to Enroll

Eligible members may enroll in the FAHP:

1. During annual open enrollment period, as long as other employer coverage has same open enrollment period or allows mid-year enrollment;[3] or
2. Due to a qualifying event, such as spouse's open enrollment or change in status (e.g. marriage, birth of child, etc.).

[3] **Note:** If the other employer-sponsored option has a different open enrollment period, try to request mid-year enrollment or you will have to wait until their open enrollment to waive HIGHLAND COMMUNITY COLLEGE medical plan, enroll in your alternative coverage, and enroll in FAHP at that time.

Premium Payroll Bonus

Your payroll bonus is calculated by the number of family members enrolled (including yourself, if also enrolled) in the FAHP, multiplied by $50 to get to a monthly bonus amount earned. This bonus is paid via standard payroll earnings and is considered taxable income. Payments start first period after your FAHP effective date.

Submitting & Receiving Claims Reimbursement

For point-of-service payments (i.e. copays), present your FAHP Debit Card to the provider and they will swipe the card to cover costs immediately. For other payments, you will receive an Explanation of Benefit (EOB) statement from the carrier—keep these in case of verification.

If you do not pay your bill with your FAHP Debit Card, complete the following steps:

1. Make a copy of the EOB and attach it to your completed Reimbursement Form.
    - Reimbursement Forms are available on My SmartCare, from your HR Department, or at www.benxcel.com.
    - A separate claim form must be filled out for each patient.
2. Submit your completed Request for Reimbursement Form and the claim substantiation to BCC:
    - Online through My SmartCare via the BCC SmartCare app or www.mywealthcareonline.com/bccsmartcare
    - Email: bcc-claims@benXcel.com; or
    - Mail: Benefit Coordinators Corporation
Attn: Claims
Two Robinson Plaza, Suite 200
Pittsburgh, PA 15205
3. Once received, BCC will process and substantiate the claim for reimbursement, sending you payment via check or direct deposit.

Questions?

BCC has a dedicated team of advisors to help answer any questions you have.

Pre-Enrollment

Submit questions, including the name of the organization you work for, to either of the following:

- Email: customersupport@benXcel.com
- Call: (412) 446 4651

BCC will review your questions, compile answers and ensure you get informed either directly or through group education.

Post-Enrollment

Advisors are available to assist you with your needs, including:

- Filing or receiving claims reimbursements
- Premium payroll bonus issues
- Debit card questions
- Anything related to FAHP Benefits

BCC Customer Service Center:

- Call:1-800-685-6100
M-TH: 8 am – 8 pm (ET), 5 am – 5 pm (PT)
F: 8 am – 6 pm (ET), 5 am – 3 pm (PT)
- Email: bcc-claims@benXcel.com

* If you are enrolled in the Highland Community College health plan through your spouse or parent, you are not eligible for FAHP.

Virtual Care

MDLive

Available to all employees enrolled on the health plan.

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.

Using your computer, tablet, or smartphone device, you can conveniently access to U.S. board-certified doctors and licensed professionals from the comfort of your home or wherever you happen to be.

In some cases, doctors can write a prescription to a local pharmacy near you.[1]

Access care wherever you are!

Connect with a virtual doctor at www.mdlive.com/bcbsil or 888-676-4202.

[1] Prescription services may not be available in all states.

MDLive	
Medical Visit	**Traditional & Copay Plans:** $0
Mental Health Visit	**HDHP:** deductible / coinsurance
Services	
Some Medical Conditions Include:	Allergies Colds, respiratory problems, flu Ear infections Sore Throat Pink eye Urinary tract infections And more!
Behavioral Health Therapists are available by appointment. Get virtual care for:	Sleep disorders Anxiety & depression Child behavior issues Eating disorders Obsessive compulsive disorders Post traumatic stress disorders Smoking addiction

Employee Assistance Program (EAP)

ComPsych® GuidanceResources®

Life. Just when you think you've got it figured out, along comes a challenge. Whether your needs are big or small this program is here for you and can help you and your family find solutions and restore your peace of mind. Best of all, this program is safe and confidential.

Employee Assistance Program	
Confidential Emotional Support	Our highly trained clinicians will listen to your concerns and help you or your family members with any issues, including: • Anxiety, depression, stress • Grief, loss and life adjustments • Relationship/marital conflicts
Work-Life Solutions	Our specialists provide qualified referrals and resources for just about anything on your to-do list, such as: • Finding child and elder care • Hiring movers or home repair contractors • Planning events, locating pet care
Legal Guidance	Talk to our attorneys for practical assistance with your most pressing legal issues, including: • Divorce, adoption, family law, wills, trusts and more Need representation? Get a free 30-minute consultation and a 25% reduction in fees.
Financial Resources	Our financial experts can assist with a wide range of issues. Talk to us about: • Retirement planning, taxes • Relocation, mortgages, insurance • Budgeting, debt, bankruptcy and more

Employee Assistance Program	
Online Support	GuidanceResources® Online is your 24/7 link to vital information, tools and support. Log on for: • Articles, podcasts, videos, slideshows • On-demand trainings • "Ask the Expert" personal responses to your questions
Benefit Cost	Company-paid – no cost to you!

Get the help you need.

Your ComPsych® GuidanceResources® program offers someone to talk to and resources to consult whenever and wherever you need them.

Your toll-free number gives you direct, 24/7 access to a consultant who will answer your questions and, if needed, refer you to a counselor or other resources.

- Call: 888-628-4844
- TTY: 800-697-0353
- Online: guidanceresources.com
- App: GuidanceResources® Now
- Web ID: DLEAP

Flex Spending Account

Flexible Benefit Service®

Available to employees enrolled in the traditional or co-pay plans.

FSAs can save you money on eligible expenses because you don't have to pay taxes on the amount contributed to the account. However, using an FSA does require careful planning to reap the financial benefits.

Is a Health FSA Right for You?
www.cbmicrosite.com/video/healthfsa

Copay Plan: One-Time Deposit

When you enroll in the copay plan option, Highland Community College will contribute a one-time deposit of up to $600 to your Flexible Spending Account (FSA) – this will not decrease the amount you are allowed to contribute to your FSA. Highland will contribute $500 whether or not the employee contributes to a Health FSA; starting at $501, however, Highland may only make a dollar-for-dollar match to the employee's contribution.

Health FSA

Pay for eligible medical, dental, vision, and prescription expenses, such as:

- Deductibles
- Copays
- Coinsurance
- Other health-related expenses

2025 annual contribution limit	$3,300

Your eligibility for an FSA may be misrepresented if you and/or your spouse currently utilize an HSA. Check with the plan administrator or Human Resources to learn more.

FSA Money "Use It or Lose It" Rule

You cannot stockpile money in your FSA. If you do not use it, you lose it. You should only contribute the amount of money you expect to pay out-of-pocket that year.

Visit www.irs.gov and search for IRS Publication 502 (Medical and Dental) to learn more about eligible expenses.

Health Savings Account

Open at the financial institution of your choice

Available to employees enrolled in the HDHP Medical Plan.

If you are enrolled in an HSA-qualified plan, you may be eligible to open a tax-free health savings account. The money in your HSA is carried over from year to year so you can budget for current and future expenses. Plus, you own the account so it's yours to keep even if you change jobs or retire.

Is an HSA Right for You?
www.cbmicrosite.com/video/hsa

HSA

Pay for eligible medical, dental, vision, and prescription expenses, such as:

- Deductibles
- Coinsurance
- Other health-related expenses

2025 annual contribution limit	Individual	$4,300
	Family	$8,550
	Catch-up contribution (Age 55 or older)	$1,000
2025 annual employer contributions*	Individual	$600
	Family	$600
Rollover		Full Amount

* This amount applies to the IRS annual contribution limit.

All HSA contributions require an open and active account. Contributions cannot be made and are forfeited if no active account exists and cannot be paid later or in a different form.

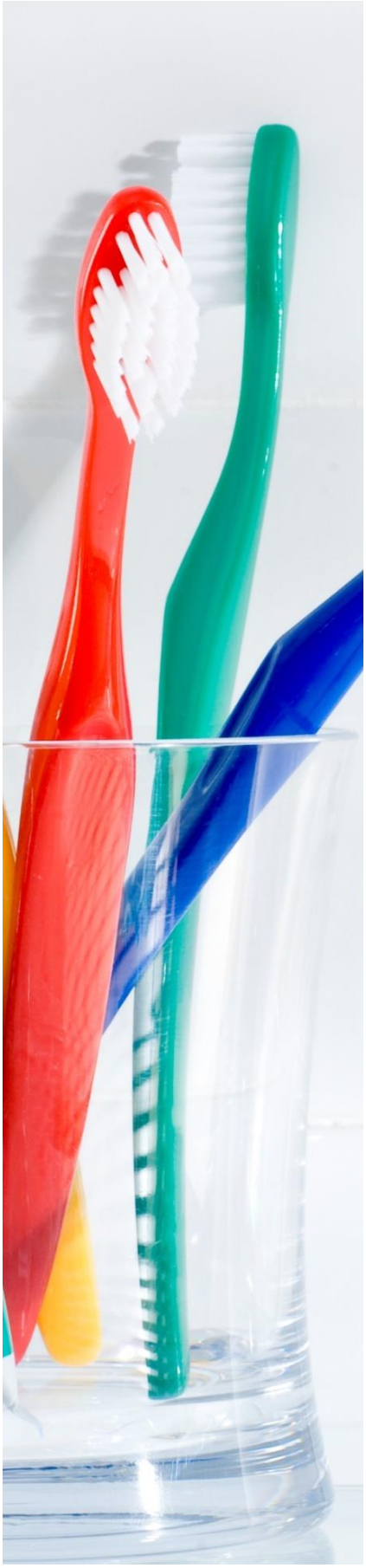
Your eligibility for an HSA may be misrepresented if you and/or your spouse currently utilize an FSA. Check with the plan administrator or Human Resources to learn more.

Visit www.irs.gov and search for IRS Publication 502 to learn more about eligible expenses.

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 $1,600 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 visit: $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 his HSA dollars in year 1, the remaining funds roll over.			Once again Justin did not spend all his HSA dollars, so they roll over to the next year.	



Dental

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.

Dental	In-Network
Annual Deductible	$50 per individual $150 per family
Annual Benefit Maximum	$1,000
Lifetime Orthodontia Maximum	$1,000
Plan Pays	In-Network
Preventive Care	100% Covered
Basic Services	20% after deductible
Major Services	50% after deductible
Orthodontia Services	50% after deductible

Locate an in-network provider near you at www.bcbsil.com/providers/dppo.htm.

Please review the full plan documents for details including out-of-network coverage. If the benefits described herein conflict in any way with the Summary Plan Description, the Summary Plan Description will prevail.

Vision

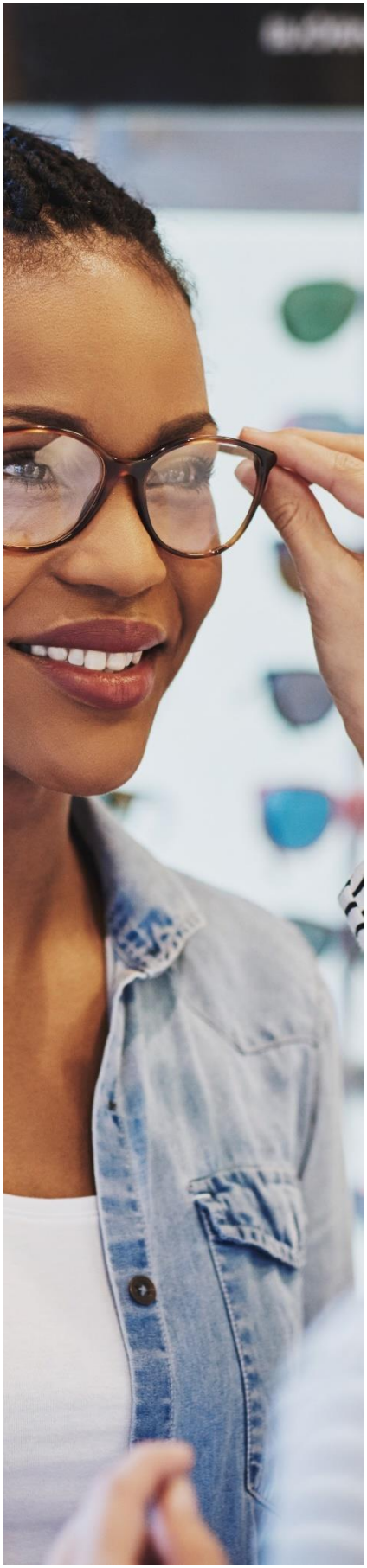
BCBS/Dearborn National Powered by EyeMed

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.

Vision	In-Network	Out-of-Network
Exam with Dilation as necessary	$10 Copay	Up to $30
Exam Option: Standard Contact Lens Fit	$40 Copay	N/A
Standard Plastic Lenses	$10 Copay	See Schedule of Benefits
Frames	$130 Allowance; then 20% off	Up to $65
Contact Lenses	$130 Allowance, then 15% off	Up to $104
Frequencies		
Exams	Once every 12 months	
Lenses	Once every 12 months	
Frames	Once every 24 months	
Contacts (in lieu of lenses/frames glasses)	Once every 12 months	

Locate an in-network provider near you at www.eyemedvisioncare.com/locator.

Please review the full plan documents for details including out-of-network coverage. If the benefits described herein conflict in any way with the Summary Plan Description, the Summary Plan Description will prevail.



Basic Life/AD&D

BCBS/Dearborn National

Life insurance protects your loved ones financially in the event of your death. Accidental death and dismemberment (AD&D) provides an additional benefit if you die or experience other covered catastrophic loss due to a covered accident.

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

Basic Life/AD&D	
Benefit Amount	1.5 times annual salary, rounded to the next higher $1,000 Minimum of $40,000 and up to $250,000
Member Benefits also include:	DearbornCares Beneficiary Resource Services Travel Resource Services
Benefit Cost	Employer-provided

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

Actively-At-Work Requirement:
New Enrollees must be actively at work on the effective date for coverage to be in force. If not, enrolled coverage will become effective upon return to Active-At-Work/eligible status.

Remember to update your beneficiaries.

It is important to update your beneficiaries and make sure they are accurate periodically. Having out of date beneficiaries listed will make it difficult to pay the benefit to the correct person in case it is ever needed.

* The value of employer-funded life insurance benefits in excess of $50,000 is taxable to you.

If you enroll when first eligible, you may receive up to the listed amount without having to answer medical questions.

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

Term Life/AD&D

BCBS/Dearborn National

Think about your personal circumstances. Are you the sole provider for your household? What other expenses do you expect in the future? Depending on your needs, you may want to consider buying supplemental coverage.

Voluntary Term Life/AD&D	
Benefit Amount	**Employee:** $10,000 to $750,000 in increments of $10,000 **Spouse:** $10,000 to $150,000 in increments of $5,000. Spouse coverage may not exceed employee's amount. **Child(ren):** Choice of $2,500, $5,000, $7,500 or $10,000 for children age 15 days up to age 26 years.
Guaranteed Issue Amount	**Employee:** $200,000 **Spouse:** $25,000 **Child(ren):** $10,000
Benefit Cost	Employee-provided – see HR for rates

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

Actively-At-Work Requirement:
New Enrollees must be actively at work on the effective date for coverage to be in force. If not, enrolled coverage will become effective upon return to Active-At-Work/eligible status.

Dependent Delayed Effective Date:
Dependents may have a delayed effective date based on his/her health status at time of the effective date. Please refer to the policy certificate or HR for more details.

Definition of "Eligible Dependents"
It is the responsibility of the employee to ensure dependents are eligible for coverage under these policies.

- **Spouse:** Eligibility may terminate at Spouse age 70.
- **Child:** Eligibility terminates earliest of age 26, married, or employed full time, or no longer a Full Time Student. Terms may vary for children with special needs. Benefits may be limited for children under age 6 months.

Please refer to the policy certificate or HR for more information.

Remember to update your beneficiaries.

It is important to update your beneficiaries and make sure they are accurate periodically. Having out of date beneficiaries listed will make it difficult to pay the benefit to the correct person in case it is ever needed.

Dependent elections require employee enrollment and may be limited by employee volume.

If you enroll when first eligible, you may receive up to the listed amount without having to answer medical questions.

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

Life/AD&D Member Benefits

Available to all members enrolled in the company-paid Basic Life/AD&D policy.

DearbornCares SM

Losing a loved one can be emotionally and financially overwhelming. This program provides an advance payment of the basic life benefit to help beneficiaries cover immediate expenses:

- Pays up to $50,000 per beneficiary of employer-paid basic life insurance benefits
- Available for covered employees and retirees
- Available on claims with up to 3 named beneficiaries
- No death certificate required

Claims Process: Once the employer is notified of the death, they will submit the life insurance claim to us, and then we will mail the payment check within 48 hours of confirmation. No additional paperwork is required at that time. Any remaining basic life benefit, if available, will be handled using our standard process. While we know this service won't fix everything, we hope it makes a difficult time a little easier.

How to access Beneficiary Resource Services

Morneau Shepell's network of experienced professionals can offer counseling for those facing emotional, financial or legal issues. Counselors are available 24 hours a day, 365 days a year. All calls are completely confidential.

Call 800-769-9187 or visit BeneficiaryResource.com, username: **beneficiary**.

Beneficiary Resource Services TM1

When a loved one dies, families often face complex issues ranging from estate planning, legal questions, funeral planning, coping with grief and financial uncertainties.

Beneficiary Resource Services combines family wellness and security at the most difficult of times. Services include grief and financial counseling, funeral planning, legal support as well as online will preparation. Beneficiary Resource Services is provided by Morneau Shepell.

Services for insureds and their Families

Online Will Preparation: You and your family have access to a full legal library with many estate planning documents, including an online will. You can create your own will online in a safe and secure way, right from your home. The will can be saved and updated as family situations change. Creating a will provides security and peace of mind for several reasons:

- Appoints a guardian for children
- Controls where property and assets go
- Provides family security

Online Funeral Planning: You have access to an online funeral planning site that features a variety of helpful tools and information, such as:

- A downloadable funeral planning guide to document vital information your loved ones will need when making final arrangements
- Calculators to estimate and compare expenses for various types of funeral arrangements
- Information on funeral requirements and various religious customs
- Directories to locate funeral homes and cemeteries in your area

Services for Beneficiaries and their Families

The following services are available after a life claim or for those who qualify for an accelerated death benefit:

- **Face-to-Face Working Sessions*:** Five face-to-face working sessions are available to you or your beneficiaries. All five sessions may be used with one grief counselor or legal advisor, or they may be split among the two types of counselors or advisors in geographically accessible locations. A one-hour financial consultation on the phone is also available.
- **Unlimited Phone Contact:** Available for up to one year with a grief counselor, legal advisor or financial planner.
- **Referrals and Support Services:** Morneau Shepell maintains a comprehensive directory of qualified and accessible grief counselors and legal and financial consultants.
- **Follow Up:** Counselors will initiate follow-up calls when necessary for up to one full year from the date of initial contact.

*May include face-to-face sessions, over-the-phone sessions or time taken for research or document preparation.

[1] Not available in all states.

Travel Resource Services ™*

To provide the support people need while traveling on business or pleasure, BCBS/Dearborn National contracts Assist America to provide Travel Resource Services, a program that assists travelers if the unexpected happens.

Around-the-clock services are available to insureds and their families traveling 100 or more miles from their primary residence.

Medical Emergency Assistance

- Medical referral
- Medical monitoring
- Emergency medical evacuation
- Foreign hospital admission assistance
- Medical repatriation
- Prescription assistance

Travel Emergency Assistance

- Compassionate visit
- Care of minor children
- Evacuation transport for family members
- Return of mortal remains
- Other services include: return of vehicle, legal & interpreter referrals, pre-trip information

How to activate Travel Resource Services

If you are traveling more than 100 miles away from home, or in a foreign country, and require assistance, contact Assist America's 24/7 Operations Center:

Your Assist America Reference Number is
01-AATRS-12201

- Download the FREE Assist America Mobile App to your phone and tap for help.
- Call 800-872-1414 (tool free within the U.S.) or +1-609-986-1234 (outside the U.S.).
- Email: medservices@assistamerica.com

*The services listed are subject to benefit amount limits. Emergency Medical Evacuation and Medical repatriation: $150,000 combined single limit. Repatriation of Mortal Remains: Up to $15,000. Care of Minor Children: Up to $5,000. Return of Vehicle: Up to $2,500. Compassionate Visit: Up to $5,000.

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.

Short-Term Disability

BCBS/Dearborn National

If you become disabled due to a covered injury or illness, disability income benefits may provide a partial replacement of lost income. This is an optional/voluntary coverage.

Short-Term Disability	
Benefit Amount	50% of the weekly earnings you were receiving at the time you became disabled, up to $2,000.
Elimination Period	7 days sickness / 7 days injury. Benefits begin on the 8th day.
Benefit Duration	Benefits continue for 12 weeks.
Benefit Cost	**Employee-paid – see HR for rates**

Short-term disability excludes work-related injury or illness.

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

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 66 2/3% of gross monthly earnings are not exceeded.

Pre-Existing Condition Limitations:
If you file a claim within the exclusion period following your plan effective date, the carrier will review to determine if the condition existed during the look back period. If so, benefits may be denied.

Actively-At-Work Requirement:
New Enrollees must be actively at work on the effective date for coverage to be in force. If not, enrolled coverage will become effective upon return to Active-At-Work/eligible status.

Statutory Benefits Offset:
Your short-term disability benefit will be reduced by benefits from State Disability/Paid Family & Medical Leave for which you may be eligible.

Short-Term Disability	
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.

Long-Term Disability

BCBS/Dearborn National

While State Universities Retirement System offers short-term disability insurance, some employees may want to purchase additional 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.

Pre-Existing Condition Limitations:
If you file a claim within the exclusion period following your plan effective date, the carrier will review to determine if the condition existed during the the look back period. If so, benefits may be denied.

Statutory Benefits Offset:
Your short-term disability benefit will be reduced by benefits from State Disability/Paid Family & Medical Leave for which you may be eligible.

Long-Term Disability	
Benefit Amount	66 ⅔% (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 Social Security Normal Retirement Age.
Pre-Existing Condition Limitations	Any condition diagnosis that happened in the 3 months prior to the effective date will not be covered for the first 12 months of the plan.
Benefit Cost	Employee-paid – see HR for rates

Actively At Work Requirement

New Enrollees must be actively at work on the effective date for coverage to be in force. If not, enrolled coverage will in force when return to Active at Work/eligible status.

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.

Supplemental Health

BCBS/ Dearborn National

The following benefits may protect your financial security in the event of an unexpected medical expense.

Accident

Helps cover the cost of expenses if you are injured in a non-work-related, covered accident.

Benefit Amount	Benefit amounts vary by severity. See schedule of benefits for details.	
Wellness Benefit	$50	
Common Covered Injuries	Dislocations Fractures	Concussions Lacerations
Common Medical Services	Ambulance Emergency room visits Hospital admission	Surgical benefits Follow-up treatments
Other Benefits	Travel Lodging	Accidental death and dismemberment

Critical Illness

Helps cover the cost of expenses if you are diagnosed with a covered condition.

Benefit Amount	**Employee:** Up $10,000 or $5,000 **Spouse:** Up to $5,000 or $2,500 **Child:** Up to $2,500	
Wellness Benefit	$50	
Pre-Existing Condition Limitations	6/12	
Common Covered Conditions	Cancer Heart attack Stroke	Major organ failure Degenerative neurological disorders

Get paid for taking care of your health!

If you are enrolled in coverage, you can receive a wellness benefit payment each year when you have a qualifying screening or test.

Hospital Indemnity

Helps cover the cost of hospital stays—including pregnancy and childbirth.

Benefit Amount	$1,000 hospital admission benefit $100 daily confinement
Wellness Benefit	$50
Pre-Existing Condition Limitations	3/12

Supplemental Health Cost	To view your personalized rates, log in to ADP

Actively-at-Work Requirement:
New Enrollees must be actively at work on the effective date for coverage to be in force. If not, enrolled coverage will become effective upon return to Active-at-Work/eligible status.

Dependent Delayed Effective Date:
Dependents may have a delayed effective date based on his/her health status at the time of the effective date. Please refer to the policy certificate or HR for more details.

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

Discount Program

PerkSpot through our partnership with Cottingham & Butler

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.

Discount Program			
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
Benefit Cost	Included in our partnership with Cottingham & Butler		

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

Unlock discounts for you and your family!

Visit: https://cottinghambutler.perkspot.com

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

Additional Benefits

HCC

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. (*90 day waiting period to use personal leave for new hires).

Paid Time Off			
Employee Group	Sick Days Per Year	Vacation Days Per Year	Personal* Days Per Year
FT Administrative	12	19	5
FT Classified, Professional	12	8 (0-5 years of service)	5
		13 (6-15 years of service)	
		18 (16+ years of service)	
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, Professional (32 hours per week)	78 hours	3 (0-5 years of service)	5
		7 (6-15 years of service)	
		11 (16+ years of service)	
PT Classified, Professional (28-31 hours per week)	72 hours	0	Pro-rated based on hours worked
PT Classified, Professional (20-27 hours per week)	48 hours	0	Pro-rated based on hours worked

Contacts

Benefit	HCC Contact	Ext.
Paid Time Off	Christie Lewis	x .3609
Direct Deposit	Renee Welch	x. 3438
Use of Library	Main Desk	x. 3539
Tuition Waivers	Renee Welch	x. 3438
Educational Assistance	Paige Offenheiser	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

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 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 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.

(Bereavement Support Services are available at no cost through the Employee Assistance Program (EAP).)

Paid Holidays

At least 12 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.

Take advantage our 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.

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.

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.

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.

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. 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. Faculty receive up to $500 per credit hour, the total allowable reimbursement shall not exceed $8,000 to any one person during any two-year period starting at the time initial coursework is commenced.
- 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 the following increase in pay after completing an Associate's degree, Bachelor's degree, Master's degree or Doctorate degree:

- Associate's degree - $500
- Bachelor's degree - $750
- Master's degree - $1,000
- Doctorate degree - $1,250

Based on the timing of the completion of the degree, the increase will be provided either January 1 or July 1 (i.e. employees obtaining degrees in May, will receive the increase effective July 1, employees obtaining degrees in August or December will receive the increase effective January 1).

This raise will be in addition to any other increase provided by the College (i.e. annual fiscal year increase). This is not 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 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 upon completion of the degree. A letter and an official transcript supporting the completion of the degree will be required for verification.

Other Perks

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.

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.*

*Tier II employees electing the self-managed plan, will follow Tier I.

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.

	Tier I – Traditional & Portable Plan Members First Employed Before Jan. 1, 2011	Tier II – Traditional & Portable Plan Members First Employed Jan. 1, 2011 or after	Tier I & Tier II Retirement Savings Plan
Employee Contributions	8% of pensionable earnings	8% of pensionable earnings	8% of pensionable earnings
Minimum Vesting	5 years of service	10 years of service	5 years of service
Retirement Age Requirements	Age 62, with at least 5 years of service Age 55, with at least 8 years of service (age reduction of 0.5% for each month under age 60 at retirement may apply) At any age, with at least 30 years of service	Age 67, with at least 10 years of service Age 62, with reduction for age, with at least 10 years of service (age reduction of 0.5% for each month under age 67 at retirement will apply)	Age 62, with at least 5 years of service Age 55, with at least 8 years of service At any age, with at least 30 years of service Age reduction is not applicable to RSP.
Retirement Benefits	Greater of the benefits computed under SURS General Formula, Minimum Annuity calculation and Money Purchase calculation. (The Money Purchase calculation is not available to members who certified on or after 7/1/2005.)	Greater of the benefits computed under SURS General Formula and Minimum Annuity calculation.	Account established in member name. Member decides how to invest using a variety of investment options including the default option, SURS Lifetime Income Strategy (LIS). Future retirement benefits are based on account balance or the amount of income secured through the LIS at retirement time.

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.

- In FY26, faculty are eligible to receive a match up to $3,000.
- In FY25, Custodial/Maintenance employees are eligible to receive a match up to $1,075 (pro-rated for part-time). Negotiations for FY26 will be determined based on the custodial maintenance union agreement.

SURS 457 Defined Contribution Plan

The SURS Deferred Compensation plan complements your SURS core retirement plan by providing an avenue to save more and generate additional retirement income. For recently hired employees who have not contributed to SURS you will be auto-enrolled in the DCP at a contribution rate of 3%. At any time before your enrollment date or in the future, you can personalize how you contribute and invest in the SURS DCP, or you can choose to opt out of enrollment in the Plan. All employees contributing to SURS are eligible to enroll. Voya Financial is the record-keeper for SURS DCP.

Healthcare Tips

Get the Most Out of Your Care

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.

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.

Where Should I Go for Care?
www.cbmicrosite.com/video/knowwheretogo

Billing & Claim Differences

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

Provider The patient receives treatment. The doctor then sends the bill to the insurance company.	>	**In-Network Discount** Appropriate discount for using an in-network provider is applied.	>	**Bill** The bill for services is presented to the insurance company. Payment responsibilities are calculated and divided between the patient and the insurance company.
				v
Patient Patient pays doctor's office for copayments, deductibles and/or coinsurance that he or she is responsible for.	<	**Insurance Company Payments, Explanation of Benefits (EOB)** 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.		

Take advantage of 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, 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.

Know Where to Go for Care

Keeping your health care costs in check could be as simple as making the right choice when you need medical care. When you have an illness or suffer an injury, you understandably want to feel better fast, but making the wrong choice about where to receive care can cost you.

The average outpatient emergency room (ER) visit costs $1,917, according to the Health Care Cost Institute. This means that if you head to the ER when you don't really need emergency care, your wallet is going to feel the pain.

Where Should I Go?

Sometimes, it can be difficult to know where to draw the line when it comes to choosing if you should go to the ER, urgent care, or your primary doctor. Here are a few guidelines to help you know where to go next time you're sick or injured.

Emergency Room ($$$$)

A visit to the ER is the most expensive type of outpatient care and should only occur if there is a true emergency, or a life-threatening illness or injury. Examples of conditions that should be addressed in the ER include, but aren't limited to:

- Chest pain
- Shortness of breath
- Uncontrollable bleeding
- Poisoning

Where Should I Go for Care?
www.cbmicrosite.com/video/knowwheretogo

Urgent Care ($$$)

Urgent care centers handle non-emergency conditions that require immediate attention—those for which delaying treatment could cause serious problems or discomfort. Urgent care visits are less expensive than ER visits but are typically more expensive than a visit to your primary care doctor. These conditions can usually be treated in urgent care centers:

- Sprains
- Ear infections
- High fevers

Doctor's Office ($$)

For most non-emergency illnesses or injuries, the best choice for medical care may be a visit to your primary care physician. Your regular doctor knows you best, has your medical history, and has the expertise to diagnose and treat most conditions. In addition, going to the doctor's office is usually the most cost-effective option.

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.

Highland Community College: Important Disclosures & Notices

Michelle's Law Notice

If the Plan provides for dependent coverage that is based on a dependent's full-time student status, then this Michelle's Law Notice applies. 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 a Leave of Absence

Your health benefits may be protected and maintained during a leave of absence, such as a leave qualifying under the Family Medical Leave Act. Other leaves of absence may, however, render you ineligible to participate in the health plan. If coverage is lost due to a leave of absence, you may be eligible to continue coverage under COBRA. Similarly, if you become ineligible for health benefits due to a leave of absence for military reasons, you may be eligible to continue that coverage under USERRA. Please contact your Human Resources Department or your manager for more information regarding what benefits are protected and maintained during a leave of absence and for more information about FMLA, COBRA and USERRA. ❖

Premium Assistance under Medicaid and The Children's Health Insurance Program (CHIP)

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 the 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 visit **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 March 17, 2025. V 0.5.0. The most recent CHIP notice can be found at https://www.dol.gov/agencies/ebsa/laws-and-regulations/laws/chipra. Contact the respective State for more information on eligibility –

ALABAMA – Medicaid
Website: http://myalhipp.com/
Phone: 1-855-692-5447

ALASKA – Medicaid
AK Health Insurance Premium Payment Program
Website: http://myakhipp.com/
Phone: 1-866-251-4861
Email: CustomerService@MyAKHIPP.com
Medicaid Eligibility:
https://dhss.alaska.gov/dpa/Pages/default.aspx

ARKANSAS – Medicaid
Website: http://myarhipp.com/
Phone: 1-855-MyARHIPP (855-692-7447)

CALIFORNIA – Medicaid
Health Insurance Premium Payment (HIPP) Program
Website: http://dhcs.ca.gov/hipp
Phone: 916-445-8322
Fax: 916-440-5676
Email: hipp@dhcs.ca.gov

COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)
Health First Colorado Website:
https://www.healthfirstcolorado.com/
Health First Colorado Member Contact Center:
1-800-221-3943/State Relay 711
CHP+ Website: https://hcpf.colorado.gov/child-health-plan-plus
CHP+ Customer Service:
1-800-359-1991/State Relay 771
Health Insurance Buy-In Program (HIBI) Website:
https://www.mycohibi.com/
HIBI Customer Service: 1-855-692-6442

FLORIDA – Medicaid
Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html
Phone: 1-877-357-3268

GEORGIA – Medicaid
GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp
Phone: 678-564-1162, Press 1
GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra
Phone: 678-564-1162, Press 2

INDIANA – Medicaid
Health Insurance Premium Payment Program
All other Medicaid
Website: https://www.in.gov/medicaid/
http://www.in.gov/fssa/dfr/
Family and Social Services Administration
Phone: 1-800-403-0864
Member Services Phone: 1-800-457-4584

IOWA – Medicaid and CHIP (Hawki)
Medicaid Website: Iowa Medicaid | Health & Human Services
Medicaid Phone: 1-800-338-8366
Hawki Website: Hawki - Healthy and Well Kids in Iowa | Health & Human Services
Hawki Phone: 1-800-257-8563
HIPP Website: Health Insurance Premium Payment (HIPP) | Health & Human Services (iowa.gov)
HIPP Phone: 1-888-346-9562

KANSAS – Medicaid
Website: https://www.kancare.ks.gov/
Phone: 1-800-792-4884
HIPP Phone: 1-800-967-4660

KENTUCKY – Medicaid
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website:
https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx
Phone: 1-855-459-6328
Email: KIHIPP.PROGRAM@ky.gov
KCHIP Website: https://kynect.ky.gov
Phone: 1-877-524-4718
Kentucky Medicaid Website:
https://chfs.ky.gov/agencies/dms

LOUISIANA – Medicaid
Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp
Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)

MAINE – Medicaid
Enrollment Website:
https://www.mymaineconnection.gov/benefits/s/?language=en_US
Phone: 1-800-442-6003
TTY: Maine Relay 711
Private Health Insurance Premium Webpage:
https://www.maine.gov/dhhs/ofi/applications-forms
Phone: 1-800-977-6740
TTY: Maine Relay 711

MASSACHUSETTS – Medicaid and CHIP
Website: https://www.mass.gov/masshealth/pa
Phone: 1-800-862-4840
TTY: 711
Email: masspremassistance@accenture.com

MINNESOTA – Medicaid
Website:
https://mn.gov/dhs/health-care-coverage/
Phone: 1-800-657-3672

MISSOURI – Medicaid
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm
Phone: 573-751-2005

MONTANA – Medicaid
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP
Phone: 1-800-694-3084
Email: HHSHIPPProgram@mt.gov

NEBRASKA – Medicaid
Website: http://www.ACCESSNebraska.ne.gov
Phone: 1-855-632-7633
Lincoln: 402-473-7000
Omaha: 402-595-1178

NEVADA – Medicaid
Medicaid Website: http://dhcfp.nv.gov
Medicaid Phone: 1-800-992-0900

NEW HAMPSHIRE – Medicaid
Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program
Phone: 603-271-5218
Toll free number for the HIPP program:
1-800-852-3345, ext. 15218
Email: DHHS.ThirdPartyLiabi@dhhs.nh.gov

NEW JERSEY – Medicaid and CHIP
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/
Phone: 1-800-356-1561
CHIP Premium Assistance Phone: 609-631-2392
CHIP Website:
http://www.njfamilycare.org/index.html
CHIP Phone: 1-800-701-0710 (TTY: 711)

NEW YORK – Medicaid
Website: https://www.health.ny.gov/health_care/medicaid/
Phone: 1-800-541-2831

NORTH CAROLINA – Medicaid
Website: https://medicaid.ncdhhs.gov/
Phone: 919-855-4100

NORTH DAKOTA – Medicaid
Website: https://www.hhs.nd.gov/healthcare
Phone: 1-844-854-4825

OKLAHOMA – Medicaid and CHIP
Website: http://www.insureoklahoma.org
Phone: 1-888-365-3742

OREGON – Medicaid
Website:
http://healthcare.oregon.gov/Pages/index.aspx
Phone: 1-800-699-9075

PENNSYLVANIA – Medicaid and CHIP
Website: https://www.pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html
Phone: 1-800-692-7462
CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov)
CHIP Phone: 1-800-986-KIDS (5437)

RHODE ISLAND – Medicaid and CHIP
Website: http://www.eohhs.ri.gov/
Phone: 1-855-697-4347 or
401-462-0311 (Direct RIte Share Line)

SOUTH CAROLINA – Medicaid
Website: https://www.scdhhs.gov
Phone: 1-888-549-0820

SOUTH DAKOTA – Medicaid
Website: http://dss.sd.gov
Phone: 1-888-828-0059

TEXAS – Medicaid
Website: https://www.hhs.texas.gov/services/financial/health-insurance-premium-payment-hipp-program
Phone: 1-800-440-0493

UTAH – Medicaid and CHIP
Utah's Premium Partnership for Health Insurance (UPP) Website: https://medicaid.utah.gov/upp/
Email: upp@utah.gov
Phone: 1-888-222-2542
Adult Expansion Website:
https://medicaid.utah.gov/expansion/
Utah Medicaid Buyout Program Website:
https://medicaid.utah.gov/buyout-program/
CHIP Website: https://chip.utah.gov/

VERMONT – Medicaid
Website: https://dvha.vermont.gov/members/medicaid/hipp-program
Phone: 1-800-250-8427

VIRGINIA – Medicaid and CHIP
Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select
https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs
Medicaid/CHIP Phone: 1-800-432-5924

WASHINGTON – Medicaid
Website: https://www.hca.wa.gov/
Phone: 1-800-562-3022

WEST VIRGINIA – Medicaid and CHIP
Website: https://dhhr.wv.gov/bms/
http://mywvhipp.com/
Medicaid Phone: 304-558-1700
CHIP Toll-free phone:
1-855-MyWVHIPP (1-855-699-8447)

WISCONSIN – Medicaid and CHIP
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm
Phone: 1-800-362-3002

WYOMING – Medicaid
Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/
Phone: 1-800-251-1269

To see if any other States have added a premium assistance program since March 17, 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 ❖

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. 15. Individuals must have enrolled or changed plans prior to Dec. 15, 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 9.02% 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 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 no later than the first day of the first month beginning after the date the plan receives a timely request for enrollment.

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. For a new spouse or dependent acquired by marriage, coverage is effective no later than the first day of the first month beginning after the date the plan receives a timely request for the enrollment. When a new dependent is acquired through birth, adoption, or placement for adoption, coverage will become effective retroactive to the date of the 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

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 Medical Plan (the "Plan"), which includes medical, dental 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 Road, Freeport, IL 61032, 815-235-6121.

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 Road, Freeport, IL 61032, 815-235-6121. 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 Road, Freeport, IL 61032, 815-235-6121. 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 Road, Freeport, IL 61032, 815-235-6121. 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 Road, Freeport, IL 61032, 815-235-6121. 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 Road, Freeport, IL 61032, 815-235-6121 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 Road, Freeport, IL 61032, 815-235-6121. 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: April 14, 2025
Name of Entity/Sender: Highland Community College
Contact--Position/Office: Human Resources
Address: 2998 W Pearl City Road, Freeport, IL 61032
Phone Number: 815-235-6121 ❖