



2026-2027 | All Employees

Benefits Guide

Your Benefits, Your Choice

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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

We understand that your life extends beyond the workplace. That's why we offer a variety of benefits to help you be an advocate of your health and well-being. Our goal is to provide choices for you and your family to be appropriately covered through all stages of life.

When to Enroll

- **Current Employees:** Open enrollment, which usually occurs in May, is your once-a-year opportunity to adjust benefit coverages and update any dependents and beneficiaries.
- **New Hires:** Once eligible, you must complete your enrollment within 31 days. Some benefits have "guarantee issue" at your first opportunity only, so please carefully consider this before you decline any coverage.



Enroll online through ADP!

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

When 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. 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 **37** for details.

What's Changed?

Benefit Highlights

Benefit changes take effect on **07/01/2026**.



Protect Your Health

- **Medical:** Coverage will continue to be offered through BCBSIL with no plan design changes and a significant adjustment to employee contributions.
- **Opt-Out Benefit Option:** Employees who have access to other medical plans or wish to purchase medical insurance outside of work (and do so), may qualify for a **\$3,600 annual benefit** (spread out over the 26 pay periods).
- **Family Advantage Health Plan:** Explore the Family Advantage Health Plan, an innovative voluntary health plan option. (\$0 out of pocket costs if you qualify).
- **Dental:** Coverage will continue to be offered through BCBSIL with no plan design change and a slight adjustment to employee contributions.
- **Vision:** Coverage will continue to be offered through EyeMed with no plan changes or adjustments to employee contributions



Protect Your Family

- **Employer-Provided Life/AD&D:** Highland Community College provides Life and AD&D insurance for all full time-employees! Be sure to update your beneficiaries during this enrollment period.
- **Voluntary Life/AD&D:** Provide financial security for your loved ones if you pass away. Health questions may be required to enroll.



Protect Your Income

- **Voluntary Short-Term and Long-Term Disability:** Protecting your paycheck is important! This insurance provides income replacement in the event you are unable to work due to injury or sickness. Pre-existing condition limitations apply.



Protect Your Wallet

- **Voluntary Accident, Critical Illness, and Hospital Indemnity:** Get cash benefits for non-work-related accidents, diagnoses such as cancer, stroke, or heart attack, or hospital stays including routine pregnancy. Each 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 21 and June 8, 2026**.



Enroll online through ADP!

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

Need Help?

Contact **Christie Lewis**

Human Resources Director, ext. 3402



Contacts

Highland Community College Benefits Contact

Christie Lewis	815-599-3402	Christie.Lewis@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	State University Retirement System (SURS)	800-275-7877	www.surs.org
	BCBS/Dearborn National	844-323-8302	dearbornnational.com
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

Eligibility

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.

Medical Plan Opt-Out Benefit

If you purchase your medical insurance elsewhere and meet the opt-out benefit requirements, you will receive a **recurring opt-out payment**. If you choose this option, you will no longer have insurance coverage through our employer-sponsored medical plan.

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.



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	\$142.38	\$115.92	\$121.47
Family	\$355.94	\$289.81	\$303.68

*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	\$3.19
Employee + Spouse	\$6.48
Employee + Child(ren)	\$6.69
Family	\$11.95

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

Basic Life/AD&D	Employer-provided
Voluntary Life/AD&D Disability Accident Critical Illness Hospital Indemnity	To view your personalized rates, log in to ADP

Medical Traditional

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.

Prescriptions are not included in the HRA plan.

Medical HRA Options	Traditional Plan - embedded	
	In-Network	Out-of-Network
Annual Deductible		
Individual	\$1,000 (\$5,000 before HRA)	\$2,000 (\$10,000 before HRA)
Family	\$2,000 (\$15,000 before HRA)	\$4,000 (\$30,000 before HRA)
Coinsurance (Plan Pays/You Pay)	80% / 20%	60% / 40%
Annual Out-of-Pocket Maximum		
Individual	\$3,000 (\$6,000 before HRA)	\$6,000 (\$12,000 before HRA)
Family	\$6,000 (\$12,000 before HRA)	\$12,000 (\$24,000 before HRA)
Services	In-Network	Out-of-Network
Preventive Care	100% Covered	40% after deductible
MDLive	\$0 Copay	-
Office Visits, Urgent Care, Labs & X-rays	20% after deductible	40% after deductible
Major Imaging (CT, MRI, PET)		
Emergency Room	20% after deductible	
Hospitalization	20% after deductible	\$300 copay + 40% after deductible
Prescription Drugs	In-Network	
Annual Out-of-Pocket Maximum		
Individual	\$500	
Family	\$1,000	
Generic	\$10 Copay	
Preferred Brand	\$35 Copay	
Non-Preferred Brand	\$60 Copay	
Specialty	\$150 Copay	

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

BCBS IL

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

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 – non embedded	
	In-Network	Out-of-Network
Annual Deductible		
Individual	\$1,700	\$1,700
Family	\$3,400	\$3,400
Coinsurance (Plan Pays/You Pay)	100% / 0%	80% / 20%
Annual Out-of-Pocket Maximum		
Individual	\$3,000	\$3,000
Family	\$6,000	\$6,000
Services	In-Network	Out-of-Network
Preventive Care	100% Covered	20% after deductible
MDLive	0% after deductible	-
Office Visits, Urgent Care, Labs & X-rays	0% after deductible	20% after deductible
Major Imaging (CT, MRI, PET)		
Emergency Room	10% after deductible	
Hospitalization	0% after deductible	\$300 copay + 20% after deductible
Prescription Drugs	In-Network	
Annual Out-of-Pocket Maximum	Included in Medical	
Individual		
Family		
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.

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Medical Copay

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	Copay Plan - embedded	
	In-Network	Out-of-Network
Annual Deductible		
Individual	\$2,000 (\$5,000 before HRA)	\$4,000 (\$10,000 before HRA)
Family	\$4,000 (\$15,000 before HRA)	\$8,000 (\$30,000 before HRA)
Coinsurance (Plan Pays/You Pay)	80% / 20%	60% / 40%
Annual Out-of-Pocket Maximum		
Individual	\$4,000 (\$6,000 before HRA)	\$8,000 (\$12,000 before HRA)
Family	\$8,000 (\$12,000 before HRA)	\$16,000 (\$24,000 before HRA)
Services	In-Network	Out-of-Network
Preventive Care	100% Covered	40% after deductible
MDLive	\$0 Copay	-
Office Visits, Urgent Care, Labs & X-rays	\$20 copay	40% after deductible
Major Imaging (CT, MRI, PET)	20% after deductible	
Emergency Room	20% after deductible	
Hospitalization	20% after deductible	\$300 copay + 40% after deductible
Prescription Drugs	In-Network	
Annual Out-of-Pocket Maximum	Included in Medical	
Individual		
Family		
Generic	\$10 Copay	
Preferred Brand	\$35 Copay	
Non-Preferred Brand	\$60 Copay	
Specialty	\$150 Copay	

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.

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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.

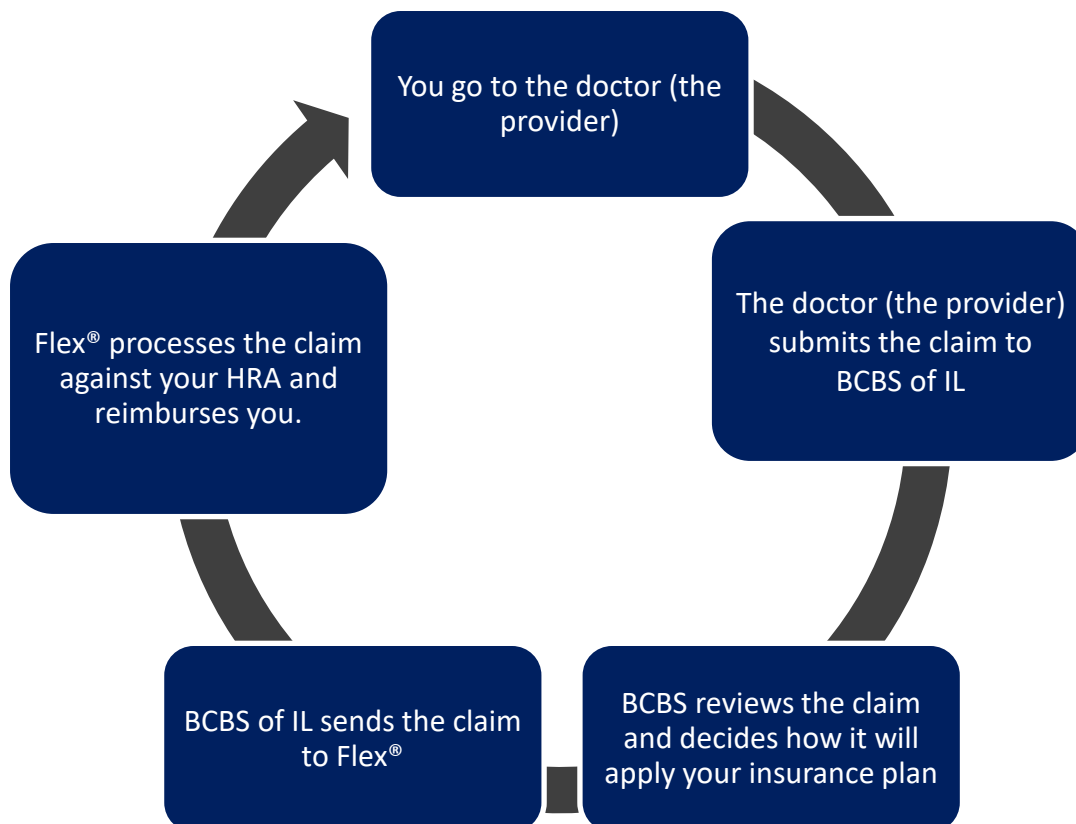
When you visit a health care provider, your claims will be filed with BCBS IL. BCBS IL will process your claim under the "Company Plan". ***If you have an FSA with Flex, funds will first be pulled from your FSA account before the bill for the remaining amount is sent to you.***

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



Embedded vs Non-Embedded Plans

BCBS IL

The biggest difference between these plan types is **when coverage begins for one family member**. In an **embedded plan**, one person can meet their own deductible and begin receiving coverage sooner. In a **non-embedded plan**, the **entire family deductible must be met first**.

Feature	Embedded Plan (Traditional & Copay)	Non-Embedded Plan (HDHP)
How the deductible works	Each family member has their own individual deductible within the family deductible.	The family shares one combined deductible.
When coverage starts for one family member	Coverage can begin for one person once that person meets their individual deductible.	Coverage does not begin for any family member until the full family deductible is met.
Do you have to meet the full family deductible first?	No. One family member may begin receiving coverage before the full family deductible is met.	Yes. The full family deductible must be met before coverage begins.
Why switching mid-year can matter	If you have already met an individual deductible, that may have helped coverage begin sooner for that person.	If you switch into this plan mid-year, prior deductible amounts may apply toward the family deductible instead, which may delay coverage.
When deductibles reset	January 1 each year.	January 1 each year.

Important if you switch plans mid-year: Your deductible and out-of-pocket amounts may carry over, but how they apply can change depending on the plan structure. Moving from an embedded plan to a non-embedded plan may mean those amounts now count toward the **family deductible**, which could result in higher out-of-pocket costs before coverage begins.

Example: If one family member has high medical expenses early in the year, that person may begin receiving coverage sooner under an **embedded plan** once their individual deductible is met. Under a **non-embedded plan**, the plan may not begin paying for anyone until the **full family deductible** is met.

Medical Member Resources

Blue Access for Members (BAM) through BCBS of IL

Blue Access for MembersSM

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 MobileSM

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 MembersSM – 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.

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 MembersSM (BAMSM). Complete the mail order form. Mail your prescription, completed order form and payment to Express Scripts® Pharmacy.

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.

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

FAHP helps lower out-of-pocket medical costs if eligible family members enroll in other employer-sponsored medical coverage.

At a Glance

- Covers eligible copays, deductibles, and coinsurance up to ACA out-of-pocket limits
- No payroll deduction to enroll
- Includes a taxable \$50 monthly payroll bonus per enrolled family member

Who Can Enroll

- Must have been on Highland medical coverage for at least 12 months
- Must be eligible for other employer-sponsored medical coverage (such as through a spouse, parent, or second job)
- Eligibility is determined person by person

Important Rules

- You cannot be reimbursed by both FAHP and an HRA/FSA for the same expense
- FAHP is not available if the other coverage includes active HSA contributions, unless they stop
- Not compatible with Medicare, Medicaid, TRICARE, individual policies, or other non-employer-sponsored coverage

How to Enroll

1. Confirm eligibility with Human Resources
2. Compare the other employer plan plus FAHP to your current Highland coverage
3. Enroll eligible family members in the other employer plan and stop any HSA contributions
4. Waive Highland medical coverage and complete the FAHP forms

When You Can Enroll

- During open enrollment, if the other employer plan allows enrollment
- After a qualifying event, such as marriage, birth, or loss/change of other coverage
- If the other employer plan has a different enrollment period, you may need to wait until that plan allows enrollment

Payroll Bonus

You receive a taxable \$50 monthly payroll bonus for each family member enrolled in FAHP, beginning after the effective date.

Claims & Reimbursement

Use your FAHP debit card for eligible copays. For other expenses, keep your Explanation of Benefits (EOB) and submit a reimbursement request to BCC.

1. Complete the reimbursement form and include the EOB.
2. Submit online through BCC SmartCare/My SmartCare, by email to bcc-claims@benXcel.com, or by mail to Benefit Coordinators Corporation, Attn: Claims, Two Robinson Plaza, Suite 200, Pittsburgh, PA 15205.
3. BCC reviews the claim and sends reimbursement by check or direct deposit.

Questions?

BCC can help before and after enrollment.

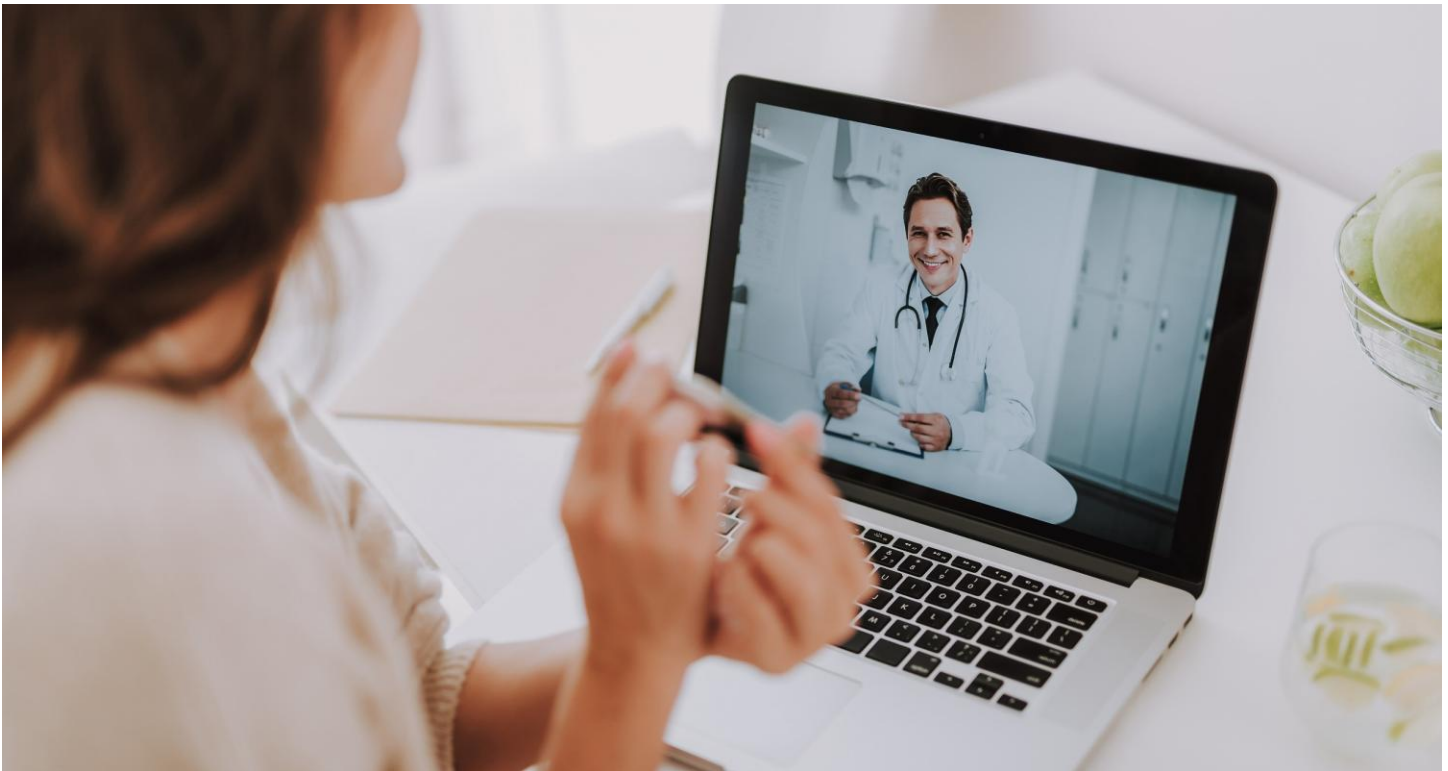
Pre-enrollment: customersupport@benXcel.com | (412) 446-4651

Post-enrollment: Claims, reimbursements, payroll bonus, debit card, and general FAHP support are available through BCC Customer Service.

BCC Customer Service Center:

- **Call:** 1-800-685-6100
M-TH: 7 am – 7 pm (CT)
F: 7 am – 5 pm (CT)
- **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 HDHP: deductible / coinsurance
Mental Health Visit	
Services	
Some Medical Conditions Include:	Allergies
	Colds, respiratory problems, flu
Behavioral Health Therapists are available by appointment. Get virtual care for:	Ear infections
	Sore Throat
	Pink eye
	Urinary tract infections
	And more!
	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	<p>Our highly trained clinicians will listen to your concerns and help you or your family members with any issues, including:</p> <ul style="list-style-type: none"> • Anxiety, depression, stress • Grief, loss and life adjustments • Relationship/marital conflicts
Work-Life Solutions	<p>Our specialists provide qualified referrals and resources for just about anything on your to-do list, such as:</p> <ul style="list-style-type: none"> • Finding child and elder care • Hiring movers or home repair contractors • Planning events, locating pet care
Legal Guidance	<p>Talk to our attorneys for practical assistance with your most pressing legal issues, including:</p> <ul style="list-style-type: none"> • Divorce, adoption, family law, wills, trusts and more <p>Need representation? Get a free 30-minute consultation and a 25% reduction in fees.</p>
Financial Resources	<p>Our financial experts can assist with a wide range of issues. Talk to us about:</p> <ul style="list-style-type: none"> • Retirement planning, taxes • Relocation, mortgages, insurance • Budgeting, debt, bankruptcy and more
Online Support	<p>GuidanceResources® Online is your 24/7 link to vital information, tools and support. Log on for:</p> <ul style="list-style-type: none"> • Articles, podcasts, videos, slideshows • On-demand trainings • "Ask the Expert" personal responses to your questions

Employee Assistance Program

Benefit Cost	Company-paid – no cost to you!
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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](https://www.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

2026 annual contribution limit

\$3,400

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



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

HSA

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

- Deductibles
- Other health-related expenses
- Coinsurance

2026 annual contribution limit	Individual	\$4,400
	Family	\$8,750
	Catch-up contribution (Age 55 or older)	\$1,000
2026 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.

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.

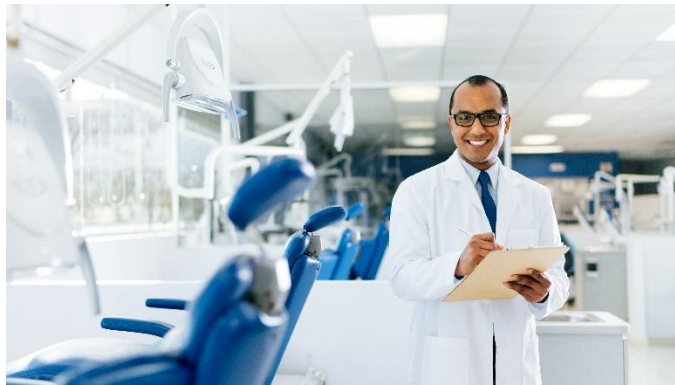
Year 1		→	Year 2	
HSA Balance	\$1,000		HSA Balance	\$1,850
Total Expenses:			Total Expenses:	
Prescription drugs: \$150			Office visit: \$100	
			Prescription drugs: \$200	
			Preventive care services: \$0 (covered by insurance)	
	- \$150			- \$300
HSA Rollover to Year 2	\$850		HSA Rollover to Year 3	\$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



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

Dental	In-Network
Annual Deductible	\$50 per individual \$150 per family
Annual Benefit Maximum	\$1,000
Lifetime Orthodontia Maximum	\$1,000
Plan Pays	
Preventive Care (Deductible waived)	100% covered
Basic	80%
Major	50%
Orthodontia	50%

Vision

BCBS/Dearborn National Powered by EyeMed



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

Vision	In-Network
Exam	\$10 copay
Exam Option: Standard Contact Lens Fit	\$40 Copay
Lenses	\$10 copay
Frames	\$130 allowance, then 20% off
Contact Lenses	\$130 allowance, then 15% off
Frequencies	
Exams	1 per 12 months
Lenses or Contacts	1 per 12 months
Frames	1 per 24 months

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.

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.

Basic Life/AD&D

Benefit Amount	1.5x 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

Voluntary Term Life/AD&D

Benefit Amount	Employee: Up to \$750,000 Spouse: Up to \$150,000 not to exceed employee's amount. Child(ren): Up to \$10,000
Guaranteed Issue Amount^{AB}	Employee: \$200,000 Spouse: \$25,000 Child(ren): \$10,000

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:

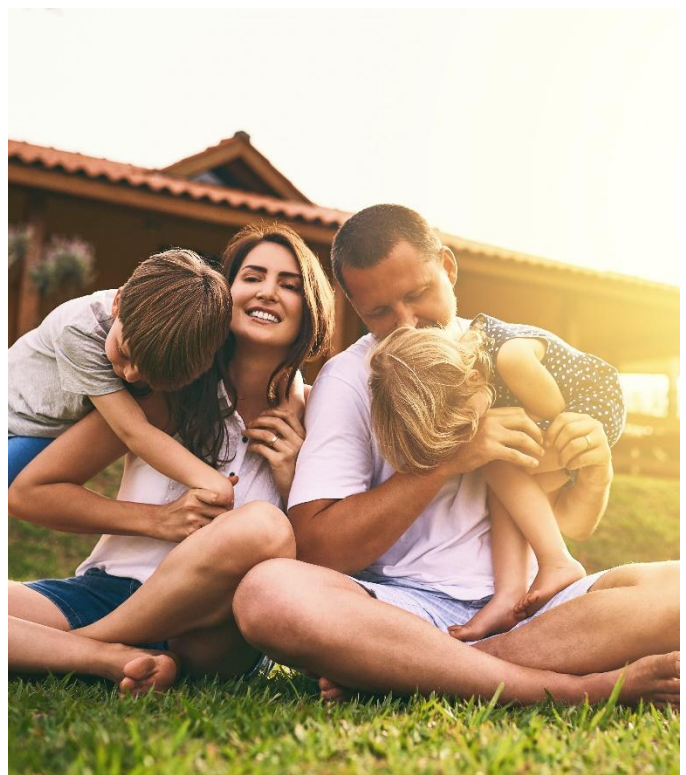
Dependents may have a delayed effective date based on his/her health status at time of the effective date. Please refer to the policy certificate or HR for more details.

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.

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

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

A 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.

Disability

SURS & BCBS/Dearborn National

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.

State University Retirement System (SURS)	
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.

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 optional/voluntary coverage. Excludes work-related injury or illness.

Short-Term Disability	
Benefit Amount	Replaces 50% of earnings, up to a \$2,000 benefit per week
Benefit Begins	After 7 days
Benefit Duration	Up to 12 weeks
Pre-Existing Condition Limitations	3-month look back period 12-month exclusion period

Long-Term Disability	
Benefit Amount	Replaces 66 2/3% of earnings, up to a \$8,000 benefit per month
Benefit Begins	After a period of 90 days
Benefit Duration	Up to Social Security normal retirement age (SSNRA)
Pre-Existing Condition Limitations	3-month look back period 12-month exclusion period

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.

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.

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 to \$10,000 Spouse: Up to \$5,000 Child: Up to \$2,500	
Wellness Benefit	\$50	
Pre-Existing Condition Limitations	6-month look back period 12-month exclusion period	
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-month look back period 12-month exclusion period

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.

Strategic Partners



Wondr Health

Available to all members covered under our Health Plan

A metabolic syndrome reversal program that helps participants build healthier eating habits and improve weight management.

Eligible employees, spouses, and adult dependents age 18+ enrolled in the BCBSIL medical plan with a BMI over 25 can enroll at wondrhealth.com/bcbsil.

Wondr Health
wondrhealth.com/bcbsil



Diabetes & Hypertension Support

Available to all adult members covered under the Traditional or Copay Plan

Combines connected devices with personalized coaching and real-time support to help members manage diabetes or high blood pressure from home.

Teladoc/Livongo
TeladocHealth.com/Now/WELL-BCBSIL
800-835-2362



Hinge Health

Available to all members 18+ covered under our Health Plan

Digital musculoskeletal support that pairs members with a dedicated physical therapist and health coach, plus sensor-based technology for guided exercise and recovery.

When you have a Musculoskeletal claim you will receive a welcome kit with instructions.

Hinge Health
Enrollment by invitation for eligible members



Ovia Health

Available to all members covered under our Health Plan

Supports fertility, pregnancy, parenting, and menopause with in-app coaching, scheduled phone coaching, and resources for a wide range of family journeys.

Ovia
Download the app
Health plan: BCBSIL
Employer: Highland Community College

Strategic Partners, Cont.



Advance Benefit Assistance

Available to all employees covered under our Basic Life policy.

Provides an advance payment of the basic life benefit to help beneficiaries cover immediate expenses

DearbornCares

800-721-7987

dearbornnational.com

Beneficiary Support Services

Available to all employees covered under our Basic Life policy.



Services for insureds and their Families

- Online Will Preparation
- Online Funeral Planning:

Services for Beneficiaries and their Families

- Face-to-Face Working Sessions
- Unlimited Phone Contact:
- Referrals and Support Services
- Follow Up

Beneficiary Resource Services

800-769-9187

BeneficiaryResource.com

username: **beneficiary.**



Travel Assistance

Available to all employees covered under our Basic Life policy.

- Medical Emergency Assistance
- Travel Emergency Assistance

Assist America

Within US: 800-872-1414

Outside US: 609-986-1234

medservices@assistamerica.com

01-AATRS-12201



Discounts

Available to all employees

This program provides you access to an online marketplace that delivers 30,000+ discounts for everyday business and personal purchases, leveraging the purchasing power of some of the largest employers in the United States.

PerkSpot through our partnership with Cottingham & Butler

<https://cottinghambutler.perkspot.com>

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	Kris Fuchs	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	Kris Fuchs	x. 3609
YMCA Membership	Stephanie Hintz	x. 3534
Bookstore Discount	Stacey Benkert	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. Match for FY27 will be determined based on the faculty union agreement.
- In FY26, Custodial/Maintenance employees are eligible to receive a match up to \$1,175 (pro-rated for part-time). Match for FY27 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.

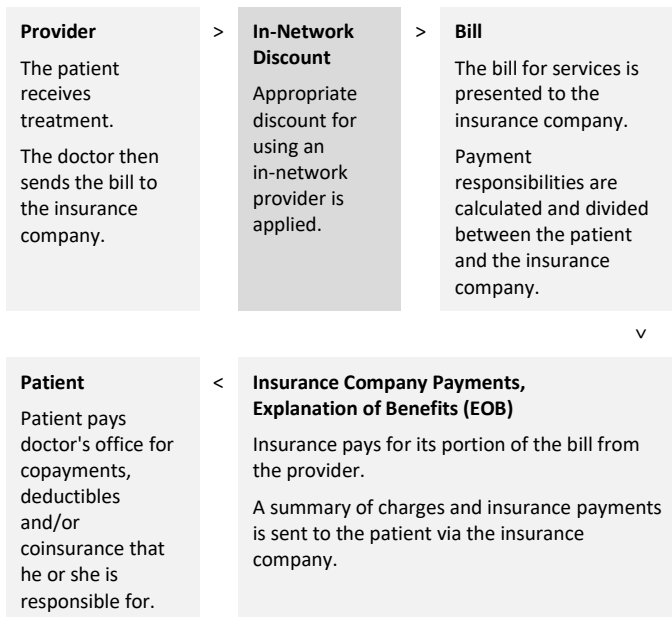


Where Should I Go for Care?

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.



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
- Uncontrollable bleeding
- Shortness of breath
- Poisoning



Where Should I Go for Care?

www.cbmicrosite.com/video/knowwheregoto

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.

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.flmedicaidtprecovery.com/flmedicaidprecovery.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](http://iowa.gov/health-human-services)
Medicaid Phone: 1-800-338-8366
Hawki Website: [Hawki - Healthy and Well Kids in Iowa | Health & Human Services](http://iowa.gov/health-human-services)
Hawki Phone: 1-800-257-8563
HIPP Website: [Health Insurance Premium Payment \(HIPP\) | Health & Human Services \(iowa.gov\)](http://iowa.gov/health-human-services)
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: KIHIPPPROGRAM@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: masspreassistance@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: HSHIPPProgram@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/client/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/hip-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://dhr.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

This Notice of Privacy Practices (the "Notice") describes the legal obligations of the Highland Community College (the "Plan") and your legal rights regarding your protected health information held by the Plan under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and the Health Information Technology for Economic and Clinical Health Act (HITECH Act). Among other things, this Notice describes how your protected health information may be used or disclosed to carry out treatment, payment, or health care operations, or for any other purposes that are permitted or required by law.

The HIPAA Privacy Rule protects only certain medical information known as "protected health information." Generally, protected health information (PHI) is health information, including demographic information, collected from you or created or received by a health care provider, a health care clearinghouse, a health plan, or your employer on behalf of a group health plan, from which it is possible to individually identify you and that relates to:

- a. Your past, present, or future physical or mental health or condition;
- b. The provision of health care to you; or
- c. The past, present, or future payment for the provision of health care to you.

We are required by law to:

- a. maintain the privacy of your PHI;
- b. provide you with certain rights with respect to your PHI;
- c. provide you with a copy of this Notice of our legal duties and privacy practices with respect to your PHI; and
- d. follow the terms of the Notice that is currently in effect.

We reserve the right to change the terms of this Notice and to make new provisions regarding your PHI that we maintain, as allowed or required by law. If we make any material change to this Notice, we will provide you with a copy of our revised Notice of Privacy Practices.

HOW THE PLAN MAY USE AND DISCLOSE YOUR PHI

Under the law, we may use or disclose your PHI under certain circumstances without your permission. The following categories describe the different ways that we may use and disclose your PHI. Not every use or disclosure in a category will be listed. Note that we will use and disclose PHI as described below unless otherwise prohibited or restricted by applicable state or other law, and that information can lose its protected status as PHI once re-disclosed by a recipient:

1. For Treatment: When and as appropriate, we may use or disclose medical information about you to facilitate medical treatment or services by health care providers. For example, we might disclose information about you with physicians who are treating you.

2. For Payment: We may use or disclose your protected health information to determine your eligibility for Plan benefits, to facilitate payment for the treatment and services you receive from health care providers, to determine benefit responsibility under the Plan, or to coordinate Plan coverage. For example, we may tell your health care

provider about your medical history to determine whether a particular treatment is experimental, investigational, or medically necessary, or to determine whether the Plan will cover the treatment. We may also share your protected health information with a utilization review or pre-certification service provider. Likewise, we may share your protected health information with another entity to assist with the adjudication or subrogation of health claims or to another health plan to coordinate benefit payments.

3. For Health Care Operations: We may use and disclose your protected health information for other Plan operations. These uses and disclosures are necessary to run the Plan. For example, we may use medical information in connection with conducting quality assessment and improvement activities; underwriting, premium rating, and other activities relating to Plan coverage; submitting claims for stop-loss (or excess-loss) coverage; conducting or arranging for medical review, legal services, audit services, and fraud and abuse detection programs; business planning and development such as cost management; and business management and general Plan administrative activities. However, we will not use your genetic information for underwriting purposes.

4. To Plan Sponsors: For the purpose of administering the plan, we may disclose PHI to certain employees of the Employer. However, those employees will only use or disclose that information as necessary to perform plan administration functions or as otherwise required by HIPAA, unless you have authorized further disclosures. Your PHI cannot be used for employment purposes without your specific authorization.

5. To Business Associates: We may contract with individuals or entities known as Business Associates to perform various functions on our behalf or to provide certain types of services. In order to perform these functions or to provide these services, Business Associates will receive, create, maintain,

transmit, use, and/or disclose your PHI, but only after they agree in writing with us to implement appropriate safeguards regarding your PHI by entering into a Business Associate Agreement with us.

6. Substance Use Disorder (SUD)

Treatment Information: Some of your health information may be part of a SUD patient record and subject to additional protections under federal law (42 CFR Part 2) governing confidentiality of SUD patient records.

If we receive or maintain any information about you from a SUD treatment program that is covered by 42 CFR Part 2 (a “Part 2 Program”) through a general consent you provide to the Part 2 Program to use and disclose the SUD patient record for purposes of treatment, payment or health care operations, we may use and disclose your SUD patient record for treatment, payment and health care operations purposes as described in this Notice. If we receive or maintain your SUD patient record through specific consent you provide to us or another third party, we will use and disclose your SUD patient record only as expressly permitted by you in your consent as provided to us. In no event will we use or disclose your SUD patient record, or testimony that describes the information contained in your SUD patient record, in any civil, criminal, administrative, or legislative proceedings by any Federal, State, or local authority, against you, unless authorized by your consent or the order of a court after it provides you notice of the court order.

7. As Required by Law: We will disclose your PHI when required to do so by federal, state, or local law. For example, we may disclose your PHI when required by national security laws or public health disclosure laws.

8. Health Oversight Activities: We may disclose your PHI to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care

system, government programs, and compliance with civil rights laws.

9. Threats to Health or Safety: We may use and disclose your PHI when necessary to prevent a serious threat to your health and safety, or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat. For example, we may disclose your PHI in a proceeding regarding the licensure of a physician.

10. Lawsuits and Disputes: If you are involved in a lawsuit or a dispute, we may disclose your PHI in response to a court or administrative order. We may also disclose your PHI in response to a subpoena, discovery request, or other lawful process by someone involved in a legal dispute, but only if efforts have been made to tell you about the request or to obtain a court or administrative order protecting the information requested.

11. Law Enforcement Purposes: We may disclose your PHI if asked to do so by a law-enforcement official:

- in response to a court order, subpoena, warrant, summons, or similar process;
- to identify or locate a suspect, fugitive, material witness, or missing person;
- about the victim of a crime if, under certain limited circumstances, we are unable to obtain the victim's agreement;
- about a death that we believe may be the result of criminal conduct; and
- about criminal conduct.

12. Coroners, Medical Examiners, or Funeral Directors: For the purpose of identifying a deceased person, we may release PHI to identify a deceased person or to determine a cause of death or other duties as authorized by law.

13. Organ or Tissue Donation: If you are an organ donor, we may release your PHI after your death to organizations that handle organ procurement or organ, eye, or tissue transplantation or to an organ donation bank, as necessary

to facilitate organ or tissue donation and transplantation.

14. Military and National Security: If you are a member of the armed forces, we may release your PHI as required by military command authorities. We may release your PHI to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

15. Workers' Compensation: We may release your PHI for workers' compensation or similar programs, but only as authorized by, and to the extent necessary to comply with, laws relating to workers' compensation and similar programs that provide benefits for work-related injuries or illness.

16. Treatment Alternatives or Health-Related Benefits and Services: We may use and disclose your protected health information to send you information about treatment alternatives or other health-related benefits and services that might be of interest to you.

17. Government Required Disclosures: We are required to disclose your PHI to the Secretary of the United States Department of Health and Human Services when the Secretary is investigating or determining our compliance with the HIPAA privacy rule.

Authorizations: Other uses or disclosures of your PHI not described above will only be made with your written authorization. For example, in general and subject to specific conditions, we will not use or disclose your psychiatric notes; we will not use or disclose your PHI for marketing; and we will not sell your PHI, unless you give us a written authorization. You may revoke written authorizations at any time, so long as the revocation is in writing. Once we receive your written revocation, it will only be effective for future uses and disclosures. It will not be effective for any information that may have been used or disclosed in reliance upon the written authorization and prior to receiving your written revocation.

HOW THE PLAN MAY USE AND DISCLOSE YOUR PHI

Under the law, we may use or disclose your PHI under certain circumstances without your permission. The following categories describe the different ways that we may use and disclose your PHI. Not every use or disclosure in a category will be listed. Note that we will use and disclose PHI as described below unless otherwise prohibited or restricted by applicable state or other law, and that information can lose its protected status as PHI once re-disclosed by a recipient:

We will comply with any restriction request if (1) except as otherwise required by law, the disclosure is to a health plan for purposes of carrying out payment or health care operations (and is not for purposes of carrying out treatment); and (2) the PHI pertains solely to a health care item or service for which the health care provider involved has been paid in full by you or another person.

To request restrictions, you must make your request in writing. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure, or both; and (3) to whom you want the limits to apply—for example, disclosures to your spouse.

Right to Inspect and Copy: You have the right to inspect and copy certain PHI that may be used to make decisions about your Plan benefits. If the information you request is maintained electronically, and you request an electronic copy, we will provide a copy in the electronic form and format you request, if possible. If we cannot agree on an electronic form and format, or you request a paper copy, we will provide you with a paper copy. We may charge a reasonable fee for the costs of copying, mailing, or other supplies associated with your request.

To inspect and copy your PHI, you must submit your request in writing. We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to your medical

information, you may request that the denial be reviewed by submitting a written request.

Right to Amend: If you feel that the PHI we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for the Plan. To request an amendment, your request must be made in writing. In addition, you must provide a reason that supports your request.

Right to an Accounting of Disclosures: You have the right to request an "accounting" of certain disclosures of your PHI. The accounting will not include (1) disclosures for purposes of treatment, payment, or health care operations; (2) disclosures made to you; (3) disclosures made pursuant to your authorization; (4) disclosures made to friends or family in your presence or because of an emergency; (5) disclosures for national security purposes; and (6) disclosures incidental to otherwise permissible disclosures.

To request this list or accounting of disclosures, you must submit your request in writing. Your request must state the time period you want the accounting to cover, which may not be longer than six years before the date of the request. There may be a charge for the cost of providing lists beyond the last 12-month period.

Right to Request Confidential Communications: You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail. To request confidential communications, you must make your request in writing. Your request must specify how or where you wish to be contacted, but you do not have to provide a reason for your request. We will accommodate all reasonable requests.

Right to a Paper Copy of this Notice: You have the right to a paper copy of this notice. You may ask us to give you a

copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice.

Right to be Notified of a Breach: You have the right to be notified in the event that we (or a Business Associate) discover a breach of unsecured PHI.

Contact Information and Complaints: If you have any questions about this Notice or about our privacy practices, and for any correspondence or requests related to the contents of this Notice, please contact Highland Community College, 2998 W Pearl City Road, Freeport, IL 61032, 815-235-6121.

If you believe that your privacy rights have been violated, you may file a complaint with the Plan or with the Office for Civil Rights of the United States Department of Health and Human Services. To file a complaint with the Plan, contact the person listed in the Contact Information section of this Notice. All complaints must be submitted in writing.

You will not be penalized, or in any other way retaliated against, for filing a complaint with the Office for Civil Rights or with us. ❖

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, 2026

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 ❖

