DATE: April 15, 2020

Joliet Junior College
1215 Houbolt Road
Joliet, IL 60431

TO:	Prospective Respondents
SUBJECT:	Addendum No. 1
PROJECT NAME:	Benefits Broker & Consulting Services
JJC PROJECT NO.:	R20010

This Addendum forms a part of the Bidding and Contract Documents and modifies the original bidding document as posted on the JJC website. Acknowledge receipt of this addendum as specified at the end of this addendum. FAILURE TO DO SO MAY SUBJECT BIDDER TO DISQUALIFICATION.

Questions Received:

1. Would it be possible to obtain copies of your benefit booklet or guide as well as open enrollment communications? ***See attached***

2. What sort of wellness initiatives are you offering and do you provide any incentives for participating? ***Currently we do not have a formalized Wellness initiative. We include wellness information in our monthly employee newsletters and we offer WW (Weight Watchers) at work. There are not incentives for participating.***

3. What are your largest cost drivers and have they been consistent year over year?

   Rx continues to be a large cost.

4. Is your pharmacy program managed by Prime or has it been carved-out? ***We have two prescriptions providers. Prime is part of the HMO plan and it is not carved out. For PPO we have Express Scripts which is carved out.***

5. What sort of resources have you received regarding COVID-19 and do you anticipate any impact on fall student enrollment? ***Our existing broker has provided numerous tools, bulletins, email communications, training and COVID related claims cost estimates.***

   As far as how this will affect fall student enrollment will depend on many factors but it may be too early to tell.

6. Who is your current broker? ***Arthur J. Gallagher***

7. What is your renewal date? ***7/1/20***

8. How much are you currently paying for your current broker services?
   $64,260

9. Who are the key carriers for administration such as TPA, Stop Loss and PBM?
   Medical/Dental (PPO/HMO) - BCBS of IL
   Stop Loss- Symetra
   Prescription – Prime Therapeutics (HMO); Express Scripts (PPO)
   Vision – VSP
   FSA and COBRA - Allied
   Life/LTD - Reliance

10. What carriers or services are you unhappy with?
    Not necessarily unhappy but will need to do RFPs for all of our carriers in 2021.

11. Profile of the Vendor (IV.) Please elaborate on item (g) under subsection (d): Delineate your risk management capabilities. We want to ensure we interpret and respond to this question appropriately

    On the employee benefits side, our risk team consists of our broker/consultant, HR, and finance.

    The college has a budget/risk manager as well as an environmental health and safety manager.

    We consult with various agencies that we belong to by way of membership (ex: IRMA), but do not have a carved out Risk Management provider.

12. Confirm the benefit programs covered within the scope of JCC's request for proposal.
    - ***Medical/Dental (PPO/HMO) - BCBS of IL***
    - ***Stop Loss- Symetra***
    - ***Prescription – Prime Therapeutics (HMO); Express Scripts (PPO)***
    - ***Vision – VSP***
    - ***FSA/COBRA - Allied***
    - ***Life/LTD - Reliance***

13. Scope of Work (VI.) Section 1. Strategic Planning, subsection (c): Please clarify if the scope of work includes assisting JCC with the selection of a third party benefits administrator or optimization of an existing system.

    Yes we will look for assistance with RFP's. We will have to go for RFP for all of our Benefit vendors in 2021.

14. Scope of Work (VI.) Section 2. Underwriting/Actuarial Services, subsection (g): To confirm, the set of services outlined in this subsection apply to health and welfare plans only. ***Applies to health, dental, prescription, stop loss, vision.***

15. Scope of Work (VI.) Section 5. Administration/Communications Support, subsection (b): In terms of communication support for new programs or changes to existing programs, if it is anticipated that the scope of work includes the development and production of faculty/staff communication materials (non-vendor materials), please provide additional guidance on the type of custom, non-vendor communication materials you have issued to faculty/staff in the past to communicate new programs or changes to existing programs.

Open enrollment materials, monthly newsletters, and sample communication on changes to employees and other constituents (e.g.: Board of Trustees).

16. Scope of Work (VI.) Section 5. Administration/Communications Support, subsection (f): Please clarify the requested scope of services related to maintenance of JCC hosted benefit website as an employee resource. For example, is the scope limited to providing JCC with content for the website or is the expectation that the selected partner will manage aspects of updating the website content, functionality, etc.

Currently we have a link on our portal that is linked to the website hosted by our broker in which all plan documents are kept. Broker is responsible for keeping data current on their website. The broker and JJC have capabilities of updating the content.

17. Proposed Pricing (VIII.) To confirm, pricing is to be provided as "a list of proposed prices for all services and materials to be used during the term of the contract", therefore, is JCC looking for annual pricing per service or pricing fr 4 years in aggregate (per Term of Contract section of RFP)?

Annual pricing. The pricing should provide what is included in the yearly pricing. Any additional services should be detailed as well with estimated pricing if chosen.

18. Proposed Pricing (VIII.) Does JCC have a preference in terms of how the proposed pricing is structured? For example, pricing provided for individual item listed in the Scope of Services, with relevant assumptions, as compared to pricing for each category of services (e.g. Strategic Planning, Underwriting/Actuarial, etc.?

Annual pricing. The pricing should provide what is included in the yearly pricing. Any additional services should be detailed as well with estimated pricing if chosen.

19. Proposed Pricing (VIII.) What are the aggregate annual insured premiums that JCC pays for the benefits that are within the scope of this project?

JJC is self-insured for medical (PPO), dental, vision, and RX (PPO). For HMO we are fully insured. Below are approximate employer costs.

Family PPO - $1,922.40 monthly cost approximate number of ee's - 411
Single PPO $ 767.11 monthly cost approximate number of ee's - 122

Family HMO $1,572.56 monthly cost approximate number of ee's - 40
Single HMO $629.02 monthly cost approximate number of ee's – 15

End of Addendum #1

DATE: April 15, 2020

Joliet Junior College
1215 Houbolt Road
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TO:	Prospective Respondents
SUBJECT:	Addendum No. 1
PROJECT NAME:	Benefits Broker & Consulting Services
JJC PROJECT NO.:	R20010

Please acknowledge receipt of these addenda by including this page with your proposal. Include your company name, printed name, title, and signature in your acknowledgement below. Failure to do so could result in disqualification of your bid.

Issued by:

Janice Reedus
Director of Business & Auxiliary Services
Joliet Junior College
815.280.6643

I acknowledge receipt of Addendum #1.

_____
Company Name

_____
Printed Name

_____
Title

_____
Signature

JOLIET
JUNIOR COLLEGE
1901

Benefit Summary

Revised 10/2019

JOLIET JUNIOR COLLEGE 1901

TABLE OF CONTENTS

BENEFITS OVERVIEW

Joliet Junior College offers a generous array of benefits to full-time employees that are effective upon the date of hire. The goal of our benefit program is to offer comprehensive health and life insurance coverage and additional benefits intended to enhance a healthy work/life balance. More detailed information related to your specific benefits package will be given during insurance orientation and annually during the open enrollment period. The benefits offered in this booklet are subject to change (see disclaimer on page 2).

Check with the Office of Human Resources (HR) for current offerings. HR manages the benefit programs for all employment classifications and any questions regarding availability and eligibility should be directed to their attention.

Eligibility

These benefits are available to all full-time employees and their dependents who meet specific eligibility requirements. In general, the plan allows coverage for an employee's legal spouse or civil union partner and/or children, including biological, adopted or step children, covered from birth to age 26, or who meet other legal requirements.

Available Benefits

BUNDLED BENEFITS (paid by Joliet Junior College)

- Medical Insurance
- Prescription Coverage
- Dental Core Insurance
- Vision Core Insurance
- Basic Life and Accidental Death and Dismemberment (AD&D) Insurance
- Employee Assistance Program (EAP)

VOLUNTARY (paid by employee)

- Dental Buy-up Insurance
- Flexible Spending Account (FSA)
- Voluntary Life and Accidental Death and Dismemberment (AD&D) Insurance
- Vision Buy-Up Insurance
- Voluntary Long-Term Disability

Important Contact Information

If you would like to ask detailed questions about your benefits, you may contact the insurance companies/service provider directly.

Benefit	Administrator	Phone	Website
Medical PPO	Blue Cross Blue Shield of Illinois	800.828.3116	www.bcbsil.com
Medical HMO	Blue Cross Blue Shield of Illinois	800.892.2803	www.bcbsil.com
Dental	Blue Cross Blue Shield of Illinois	800.367.6401	www.bcbsil.com
Prescription Drugs PPO	Express Scripts	800.818.6632	www.express-scripts.com
Prescription Drugs HMO	Prime Therapeutics	800.423.1973	primetherapeutics.com
Employee Assistance Program (EAP)	ComPsych	833.962.0004	guidanceresources.com
Vision	Vision Service Plan	800.877.7195	www.vsp.com
Flexible Spending Account	Allied	312.906.8080	www.alliedbenefit.com
Life & AD&D and Voluntary Long Term Disability	Reliance Standard	800.351.7500	www.reliancestandard.com
State Universities Retirement System	State Universities Retirement System	800.275.7877	www.surs.org

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Dependent Enrollment Requirements

If you enroll your dependents, you may be required to submit additional proof documentation with your enrollment. Please see proof documents listed on page 5.

Coordination of benefits rules apply if you have dependents enrolled with other Medical Insurance.

Changing Your Benefits During the Year

It is important that you make your elections during your enrollment period because you can only make changes during the year if you have a **qualified life event** according to IRS regulations listed below.

Changes to your benefits can be made if preceded by a **documented qualified life event** and they are made within 31 days of the event. Your change must be consistent with your life event/status change. The following events qualify for a change in coverage:

- Marriage
- Civil Union
- Divorce or legal separation
- Birth or placement for adoption of a child
- Death of a dependent
- Ineligibility of a dependent
- Loss of other coverage
- Change in your employment status or that of your spouse
- Significant change in health coverage attributable to your employment or that of your spouse
- A court order
- Entitlement to Medicare or Medicaid

If you experience one of these events and want to change your benefits, you must make the change within 31 days after the event occurs. Contact your Human Resource Department for details to ensure the change is made correctly. If you miss the window for making a change, you will need to wait until the next open enrollment period to make a change.

Enroll/Waive

A waiver is required from all employees that choose not to accept offered coverage or that have coverage elsewhere.

Coordination of Benefits

This Coordination of Benefits (COB) provision applies when a person has healthcare coverage under more than one Plan.

The order of benefit determination rules govern the order in which each Plan will pay a claim for benefits. The Plan that pays first is called the Primary Plan. The Primary Plan must pay benefits in accordance with its policy terms without regard to the possibility that another Plan may cover some expenses.

The Plan that pays after the Primary Plan is the Secondary Plan. The Secondary Plan may reduce the benefits it pays so that payments from all plans do not exceed 100% of the total Allowable Expense.

REQUIRED PROOF DOCUMENTS FOR DEPENDENT COVERAGE

JOLIET JUNIOR COLLEGE 1901

Legal Marriage

- Marriage certificate
- Civil Union certificate

Biological Child

- One of the following:
  - » Birth certificate of biological child
  - » Documentation on hospital letterhead indicating the birth date of child(ren) under 6 months old

Adopted Child

- One of the following:
  - » Official court/agency papers (initial stage)
  - » Official Court Adoption Agreement (mid-stage)
  - » Birth certificate (final stage)

Foster Child

- Official court or agency placement papers

Stepchild

- Child's Birth Certificate showing the child's parent is the employee's spouse
- Marriage Certificate showing legal marriage between the employee and the child's parent
- Court document showing that your spouse has custody of the child or is required to cover child

Other Child

- Court papers demonstrating legal guardianship, including the person named as legal guardian

Court-Ordered Medical Coverage

- One of the following:
  - » Qualified Medical Child Support Order (QMCSO)
  - » National Medical Support Notice (NMSN)

Child Age 26 or Older

- Certified Handicapped Child/Disabled Student Attending Physician Statement signed by the employee and the child's attending physician
- DD-214 military documents showing honorable discharge from military branches

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YOUR MEDICAL INSURANCE

Where to Go for Answers

- **Blue Cross and Blue Shield of Illinois is the claims administrator for the PPO and HMO plan.** They determine if you and your dependents are eligible for benefits and process your claims. Contact Blue Cross for questions concerning benefits or status of claim payments. PPO Customer Service can be reached at **800.828.3116** between the hours of 8:30 a.m. and 6:00 p.m. CST Monday through Friday and HMO Customer Service can be reached at **800.892.2803** between the hours of 8:30 a.m. and 6:00 p.m. CST Monday through Friday.
- **Blue Cross has established a Utilization Review program for the PPO.** They work with your doctor to ensure you are getting the most appropriate care, in the appropriate setting for Inpatient Admissions, Coordinated Home Care, Private Duty Nursing and certain Mental Health procedures. Contact them at **800.826.8551**, 7:00 a.m. to 7:00 p.m., CST, Monday through Friday. Failure to notify Blue Cross 24 hours prior to a non-emergent admission or 48 hours after an emergency or maternity admission could result in a penalty.
- **Blue Cross and Blue Shield of Illinois** website is user friendly and informative. You can locate doctors and hospitals participating in the network. The Blue Access site allows you to email customer service with questions, check the status of a claim, print a medical claim form, print a temporary ID card and request a duplicate ID Card. You can also review the Blue 365 program, which offers discounts on vision care and other services. Their web address for members is **www.bcbsil.com**.
- **Prime Therapeutics** is your HMO Prescription Benefit Manager. Retail prescriptions can be obtained through participating pharmacies by presenting your Blue Cross ID Card. Mail order information can be obtained on the Blue Cross website at **www.bcbsil.com**. You can also view the formulary, locate a participating pharmacy, order refills, etc., on the website. If you have specific questions or issues, please call **800.423.1973**. Please see page 7 for details on copays.
- **Express Scripts** is your PPO Prescription Benefit Manager. Mail order information can be obtained on the Express Scripts website at **www.express-scripts.com** or by calling **800.818.6632**. You can also view the formulary, locate participating pharmacies, order refills, etc. on the website. Please see page 7 for details on copays.

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JJC Medical Plan Comparison

	PPO Plan		HMO Plan
	In-Network Plan Pays	Out-of-Network Plan Pays	In-Network
Lifetime Maximum	Unlimited		Unlimited
Deductible[1]			
Individual	$1,000	$2,000	N/A
Family	$2,000	$4,000	N/A
Coinsurance	80%	60%	N/A
Out-of-pocket limit[2]			
Individual	$2,500	$5,000	$1,500
Family	$5,000	$10,000	$3,000
Covered Expenses			
Hospital			
Inpatient Services	80% after deductible	60% after deductible	$100 copay, 100%
Outpatient Services	80% after deductible	60% after deductible	$0 copay, 100%
Emergency Room	$200 copay, then 80%		$100 copay, then 100%
Physician Services			
Primary Care Office Visits	$30 copay, then 100%	60% after deductible	$30 copay
Specialist Office Visits	$50 copay, then 100%	60% after deductible	$50 copay
Preventive Care	100%	60% no deductible	100%
Medical/Surgical Services	80% after deductible	60% after deductible	100%
Other			
Chiropractic	80% after deductible	60% after deductible	Only if referred by PCP, then copay
Speech, Occupational or Physical Therapy	80% after deductible	60% after deductible	100%, 60 visit maximum
Prescription Drugs	Express Scripts		Prime Therapeutics
Participating Retail Pharmacy (30-day supply)	$10 Generic $25 Formulary Brand $40 Non-formulary Brand		$10 Generic $25 Formulary Brand $40 Non-formulary Brand
Participating Retail Pharmacy (90-day supply)	$20 Generic $50 Formulary Brand $80 Non-formulary Brand		$20 Generic $50 Formulary Brand $80 Non-formulary Brand
Mail Order PPO (90-day supply)	$10 Generic $25 Formulary Brand $40 Non-formulary Brand		$20 Generic $50 Formulary Brand $80 Non-formulary Brand
Prescription Drug Out-of-pocket maximum	$2,500 individual $5,000 family		$1,000 individual $2,000 family

[1] Deductibles are based on calendar year.

[2] The out-of-pocket limit includes the deductible.

Note: This slip sheet is an outline of the benefit schedule. This exhibit in no way replaces the plan document of coverage, which outlines the plan provisions and legally governs the operation of the plans.

YOUR BUNDLED BENEFITS INCLUDE MEDICAL, RX, CORE DENTAL AND CORE VISION

JOLIET JUNIOR COLLEGE 1901

Medicare/Retirement

Medicare and Group Health Plan Coverage

When you turn 65, you have a number of important decisions to make. These may include whether to enroll in Medicare Part B, join a Medicare Prescription Drug Plan, buy a Medigap policy, and/or keep employer or retiree coverage. Understanding your choices may help you avoid paying more than you need to for Medicare Part B and other insurance, and get the coverage that's best for you. You can visit **www.medicare.gov** and select "Compare Medicare Prescription Drug Plans" and "Compare Health Plans and Medigap Policies in Your Area." You can also call your State Health Insurance Assistance Program. To get their telephone number, call **800.MEDICARE** (8**00.633.4227**). TTY users should call **877.486.2048**.

Medicare Part B benefits are optional and are available to all beneficiaries when they become entitled to Medicare Part A. Medicare Part B may be purchased by most persons age 65 and over. Although participation in Medicare Part B is optional, JJC's health plans will pay as if Medicare Part B has been elected when Medicare is primary. See chart below to determine when Medicare is primary. **Failure to purchase Medicare Part B when Medicare is primary will drastically affect an individual's ability to recover any costs incurred for physician services and other Medicare Part B covered items.**

Medicare Part D (prescriptions)

Those eligible for Medicare are provided a letter of creditable coverage. The letter states that the prescription drug program currently provided by JJC Healthcare Plan meets or exceeds Medicare Part D. Medicare participants were advised that they could select the JJC prescription drug plan instead of Medicare Part D. The letter permits Medicare eligible persons to join Medicare Part D at a later date, if they choose, without paying a late entrant "penalty." This letter will be provided annually.

Who Pays First?

If You	Situation	Pays First	Pays Second
Are 65 or older and covered by a group health plan because you or your spouse is still working	Entitled to Medicare	Group Health Plan	Medicare
	The employer has 20 or more employees		
Have an employer group health plan after you retire and are 65 or older	Entitled to Medicare	Medicare	Retiree Coverage

Coordination of Benefits

This Coordination of Benefits (COB) provision applies when a person has healthcare coverage under more than one Plan.

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The Plan that pays after the Primary Plan is the Secondary Plan. The Secondary Plan may reduce the benefits it pays so that payments from all plans do not exceed 100% of the total Allowable Expense.

EXPRESS SCRIPTS – PPO MEMBERS

Express Scripts is the Prescription Benefit Manager for PPO Plan Participants

Retail prescriptions can be obtained through participating pharmacies by presenting your Express Scripts ID Card. Mail order information can be obtained on the Express Scripts website at **www.express-scripts.com**. You can also view the formulary, locate a participating pharmacy, order a refill, etc., on the website. If you have specific questions or issues, please call **800.818.6632**.

Express Scripts Mobile

Information in the palm of your hands!

- Claims History – View your past prescription activity and payment details
- Medicine Cabinet – Manage prescriptions and check for drug interactions
- Refills & Renewals – Refill and renew home delivery prescriptions
- Order Status
- Pharmacy Care Alerts – Personalized alerts for your treatment plan
- Locate a Pharmacy – Find the one closest to you
- Switch to Home Delivery – Save the runaround, and maybe some money
- Drug Information – Get more detailed medication info
- Prescription ID Card
- My Rx Choices – Find lower-cost options

Watch out for mobile pharmacist and price a medication that are coming soon features. To download the app today, visit the app store or visit **Express-Scripts.com/mobileapp**.

Express Scripts Web

Get the most from our prescription benefit through **www.express-scripts.com**.

- Prescriptions and Benefits
  - » Track your prescriptions and home delivery refills
  - » Refill and renew many prescriptions automatically with Worry-Free Fills
  - » View claims, balances and prescription history
- My Account
  - » Receive online alerts if there's a prescription-related safety issue
  - » Search information about any drug on the market
  - » Find lower-cost options
- Health Resource Center – Connect with pharmacists who specialize in medications used to treat long-term health conditions like:
  - » Cardiovascular disease
  - » Diabetes
  - » Oncology
  - » Bleeding disorders
  - » Other complex and chronic conditions

PetRx

Health care costs for pets can be expensive, especially if you are dealing with expenses for prescriptions treating chronic conditions. We have partnered with Inside Rx℠ Pets, a prescription savings program to provide discounts on brand and generic human medications prescribed for pets at 40,000 participating retail pharmacies. Simply present the card along with the prescription from your veterinarian at a participating pharmacy to save.

When an employee uses the Inside Rx Pets card, they'll receive:

- 77% average savings on the cost of generic medications
- 15% average savings on the cost of brand medications
- No membership fees or registration required so you can begin using the card right away
- Access to online pricing tools and pharmacy locator
- Easy access by printing the card or using it electronically through Google Pay or Apple Wallet

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PRIME THERAPEUTICS – HMO MEMBERS

Prime Therapeutics is the Prescription Benefit Manager for HMO Plan Participants.

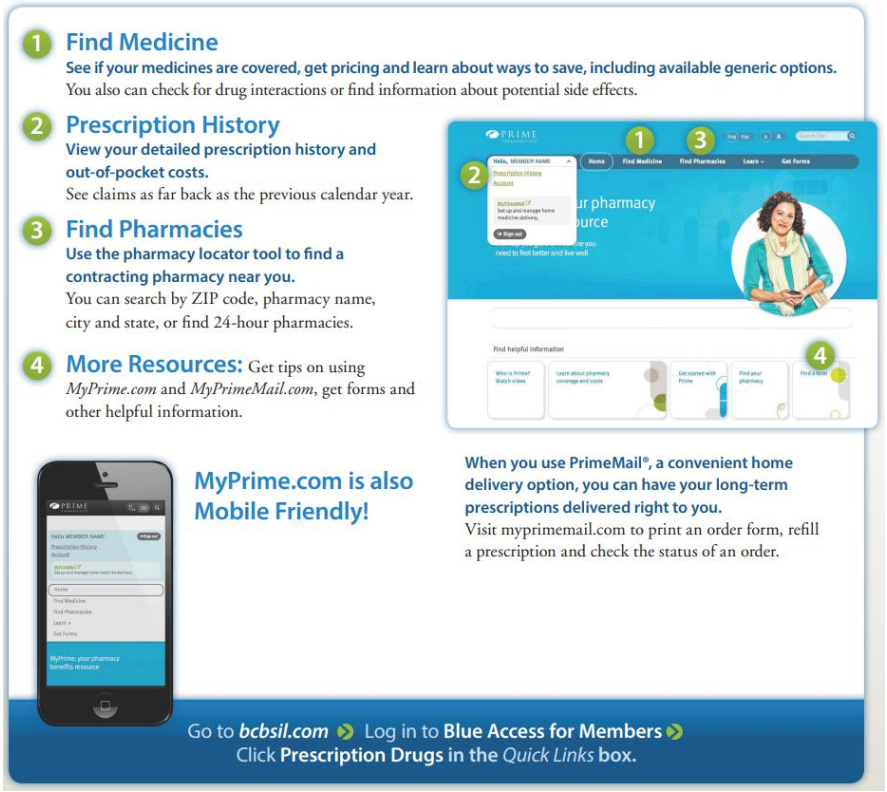
Prime Therapeutics offers many options, resources and advantages as the pharmacy benefits manager through BCBSIL.

- Cost savings: Using generic drugs, when right for you, can help you save money. If you are taking or are prescribed a brand drug, visit **www.bcbsil.com** or **www.myprime.com** to find out if generic options are available.
- Convenience: A broad pharmacy network allows you to choose a contracting retail pharmacy close to you.
- Time savings: Through mail service, you can have maintenance medications delivered directly to you.
- Safety programs: BCBSIL has programs that help identify potential safety concerns.

In your Blue Access for Members portal click prescription drugs in the quick links box on the right. This will take you to **www.myprime.com**, the member site of BCBS pharmacy benefit manager. At **www.myprime.com** you will find a variety of tools that can help you learn more about your medication, estimate prescription drug costs and help you better communicate with your doctor about your prescription medication options.

Use *www.myprime.com* to:

- Find out if a drug is on your plan's formulary. Using formulary drugs usually costs you less.
- See a list of generic options for a brand medication and learn more about generic drugs. Using generic drugs can save you money.
- Calculate your estimated cost for a 30-day or 90-day supply of a covered medication.



BLUE CROSS PROGRAMS AND RESOURCES

JOLIET JUNIOR COLLEGE 1901

FOR HMO AND PPO MEMBERS

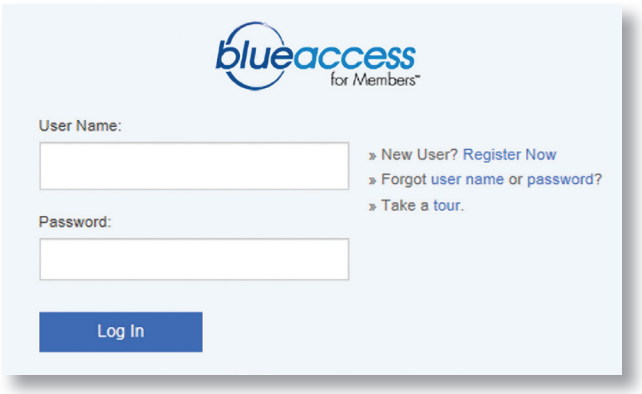
As a Blue Cross and Blue Shield member you have access to a number of valuable programs and resources at no additional cost. For more information, visit **www.bcbsil.com** and login to your Blue Access for Members portal.

Blue Access for Members

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

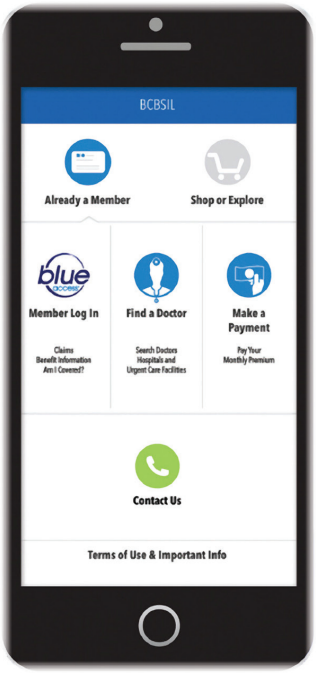
With BAM, you can:

- Check the status or history of a claim
- View your benefits
- Confirm who is enrolled and covered on your plan according to Blue Cross
- View or print Explanation of Benefits statements
- Locate a doctor or hospital in your plan's network
- Request a new ID card—or print a temporary one
- Navigate through the health and wellness tools
- See what discounts you have available just because you are a member



Blue Access Mobile App

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



From the mobile app you can:

- Register or log in to your secure member site Blue Access for Members to view coverage details, access or request 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
- Locate Blue Cross contact information
- Text BCBSILAPP to **33633** to get the app or download at the App Store or Google Play.

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FOR HMO AND PPO MEMBERS

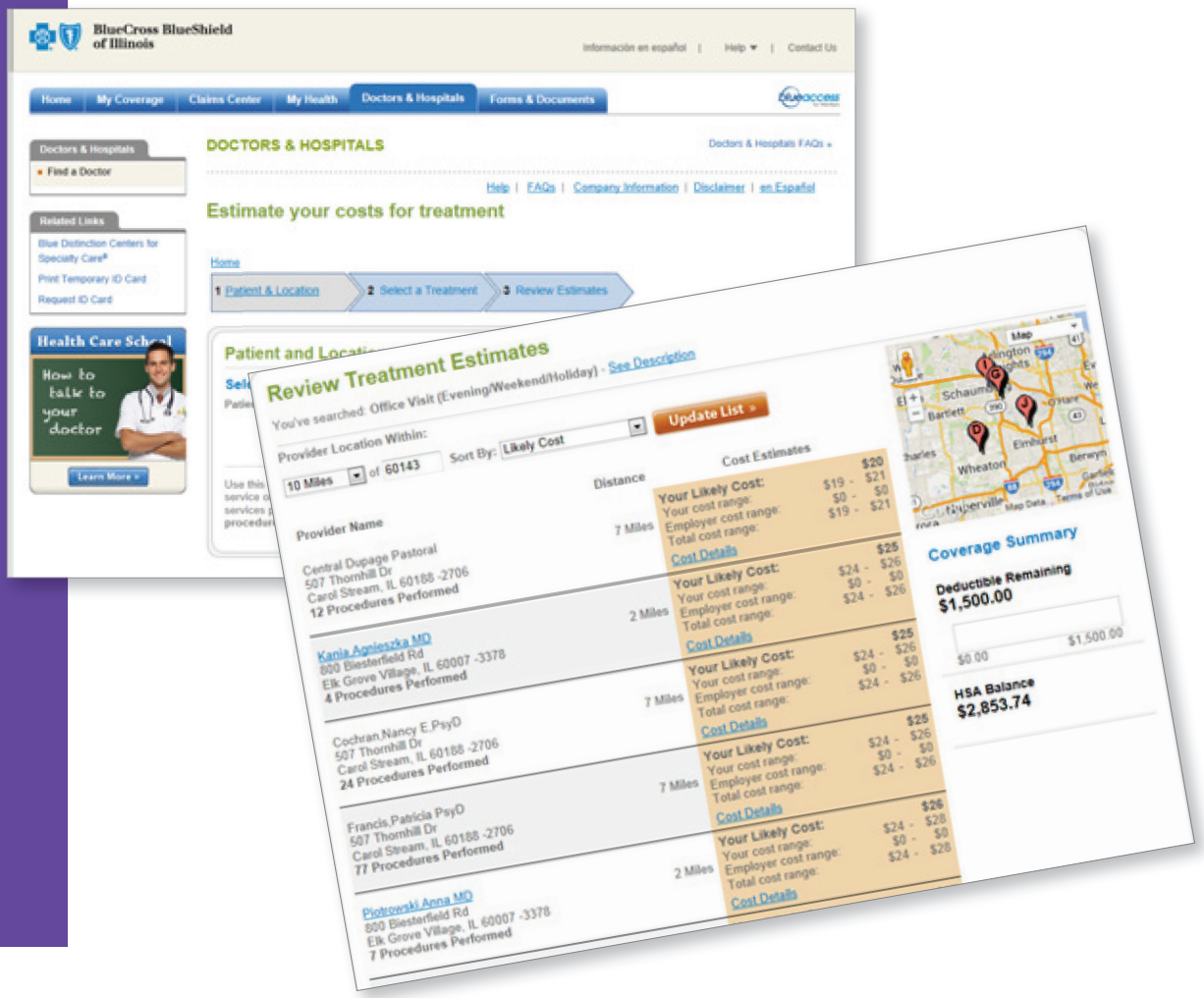
Provider Finder

The Provider Finder from Blue Cross is an innovative tool for helping you choose a provider and estimate healthcare costs. Since cost and quality rating for same service can greatly vary based on the facility in which the service is preformed Blue Cross offers this tool so you can be well informed as a consumer.

By logging in to Blue Access for Members either online or via your mobile device you can use the Provider Finder to:

- Find a network primary care physician, specialist or hospital
- Filter search results by doctor, specialty, ZIP code, language and gender. Even get directions from Google Maps™!
- Estimate the cost of a provider's procedures, treatments and tests—and gauge out-of-pocket expenses
- Determine if a Blue Distinction Center for Specialty Care® is an option for treatment
- View patient feedback or add a provider review
- Review providers' certifications and recognitions
- View clinical quality ratings from Blue Cross as well as independent third parties

The Provider Finder shares information that puts you in charge!



JOLIET JUNIOR COLLEGE 1901

FOR HMO AND PPO MEMBERS

Enable Wellbeing Management

Blue Cross offers the following programs through Wellbeing Management, a program to help you and your covered family members reach your health. The Enable Wellbeing Management program is designed to help you take charge of your health and provide you with the tools to better manage your benefits.

Holistic Health Management

A care team, led by a health advisor, collaborates to deliver tailored interventions that may help members adhere to their care plan, improve health outcomes and drive savings. Members can interact with their health advisor through a variety of convenient channels, including the ability to schedule a callback.

- Multidisciplinary clinical team
- Health advisor that focuses on member and family

Advanced Analytics

State-of-the-art algorithms help health advisors deliver interventions that can have the greatest impact on health outcomes and cost of care.

Messaging for Gaps in Care

Get personalized reminders for your annual visits, preventive screenings and immunizations.

Utilization Management

Evidence-based care yields improved health and financial outcomes. The BCBS Utilization Management processes help prevent misuse and overuse, which can improve member health and reduce medical spend. Programs address the full spectrum of health care costs, including:

- Inpatient services
- Select outpatient services
- Specialty drug review

Well onTarget®

When you feel well, you do well. But wellness involves more than just encouraging a sensible diet and exercise. That's why BCBS developed Well onTarget, an innovative solution that promotes good health across your entire organization, offering personalized initiatives no matter where you are on your wellness journey.

Well onTarget features include:

- **Member Wellness Portal –** A comprehensive, adaptable online portal that engages you through useful health resources, goal trackers, tools and more:
  - » Onmyway Health Assessment – Answer survey questions that assess their current health status. The results help identify health risks and define a personalized program with individual wellness goals.
  - » Health and Wellness Content – Online health encyclopedia that educates and empowers through evidence-based, consumer-friendly content.
  - » Onmytime Self-directed Courses – A suite of structured courses to help achieve health and wellness goals. Topics include nutrition, exercise, weight and stress management and tobacco cessation. Reach your milestones and earn Life Points.

FOR HMO AND PPO MEMBERS

  - » Tools and trackers – Interactive tools help keep you on course while making wellness fun. Use a food and exercise diary, symptom checker and health trackers.
  - » Life Points – A rewards program that reinforces positive lifestyle changes, such as more time at the gym or healthier meal choices.
- **Onmyteam Wellness Coaching –** Professionally certified coaches counsel employees on nutrition, physical activity and stress management, fostering sustained involvement through phone contact or secured messaging via the interactive member portal.
- **Fitness Program –** Fitness can be easy, fun and affordable. The Fitness Program is a flexible membership program. Gain unlimited access to a nationwide network of fitness centers. With more than 8,000 gyms on hand, you can work out at any place or at any time. Choose a gym close to home and one near your office.
  - » No long-term contracts required. Membership is month to month. Monthly fees are $25 per month per member, with a onetime enrollment fee of $25
  - » Automatic withdrawal of monthly fee
  - » Online tools for locating gyms and tracking visits
  - » Earn 2,500 bonus Life points for joining the Fitness Program and up to 500 points with weekly visits
  - » Sign up for the fitness program by calling **888.762.BLUE (2583)**

Blue365

With this program, you can save money on healthcare products and services that are not covered by insurance. There are no claims to file and no referrals or preauthorizations. Blue365 has a range of deals from top national and local retailers on dental, vision and hearing services, fitness gear, gym memberships, healthy eating options and much more.

Sign up on the Blue365 website at **blue365deals.com/BCBSIL** and start receiving weekly "Featured Deals." These deals offer savings from leading health companies and online retailers. Featured Deals are offered for a short period of time. In addition, below are some of the Blue365 deals available to you.

- **Davis Vision –** You can save on eyeglasses as well as contact lenses, exams and accessories. The Davis Vision group is made up of national and regional retail stores as well as local eye doctors. Save on laser vision correction through the TLC/ TruVision group.
- **Dental Solutions –** You can receive a dental discount card, which provides access to discounts up to 50 percent at more than 61,000 dentists and more than 185,000 locations.
- **Jenny Craig, Seattle Sutton's, Nutrisystem –** Save on healthy meals, membership fees (where apply), nutritional products and services.
- **Procter & Gamble (P&G) Dental Products –** You can get savings on dental packages with Oral B power toothbrushes and Crest products. Packages may include items such as an electric toothbrush, mouth rinse, teeth whiteners and floss.
- **TruHearing –** You can save an average of $890 per hearing aid compared to national retail prices. Each hearing aid comes with a 45-day money-back guarantee and a three-year warranty.
- **CORD:USE –** Protect your family's cord blood at a state-of-the-art laboratory using high-quality cord blood banking practices and technologies. Save on cord blood processing and storage fees.
- **Reebok –** You enjoy 20% off plus free shipping on their whole **Reebok.com** order.
- **SeniorLink Care –** You can find support to help your aging family members or friends lead fulfilling and comfy lives. From planning care to helping caregivers, SeniorLink helps seniors and loved ones find the programs and services they need most. You can save on a 3-month or 12-month membership.
- **BodyMedia –** You can enjoy up to 25% off a BodyMedia armband. The armband will track calories around the clock, helping members lose weight, stay active and lead healthier lives.

JOLIET JUNIOR COLLEGE 1901

FOR PPO MEMBERS

24/7 Nurseline

Around-the-Clock, Toll-Free Support

Health concerns don't always follow a 9-to-5 schedule. Fortunately, registered nurses are on call at **800.299.0274** to answer your health questions, wherever you may be, 24 hours a day, 7 days a week.

The 24/7 Nurseline's registered nurses can understand your health concerns and give general health tips. Get trusted guidance on possible emergency care, urgent care, family care and more.

When should you call?

The toll-free Nurseline can help you or a covered family member get answers to health problem questions, such as:

- Asthma, back pain or chronic health issues
- Dizziness or severe headaches
- High fever
- A baby's nonstop crying
- Cuts or burns
- Sore throat

Plus, when you call, you can access an audio library of more than 1,000 health topics—from allergies to women's health—with more than 600 topics available in Spanish.

Note: For medical emergencies, call 911 or your local emergency services first. This program is not a substitute for a doctor's care. Talk to your doctor about any health questions or concerns.

Special Beginnings®

Special Beginnings can help you better understand and manage your pregnancy. Available at no additional cost, this maternity program supports you from early pregnancy until six weeks after delivery through:

- Pregnancy risk factor identification to determine the risk level of your pregnancy and appropriate range for ongoing communication/monitoring.
- Educational material including a complimentary book about having a healthy pregnancy and baby.
- Personal telephone contact with program staff to address your needs and concerns and to coordinate care with your physician.
- Assistance in managing high-risk conditions such as gestational diabetes and preeclampsia.
- Special Beginnings Online is an additional resource that provides information for each week of your pregnancy. The site can be accessed through Blue Access for Members℠.

Take good care of yourself and your baby—enroll in Special Beginnings today!

Enrollment is easy and confidential. Just call **888.421.7781**, 8 a.m. – 6:30 p.m., CT.

JOLIET JUNIOR COLLEGE 1901

FOR PPO MEMBERS

Doctor, Retail Clinic, Urgent Care or ER Guidance

Blue Cross offers a quick reference guide for PPO network treatment resources.

Sometimes it's easy to know when you should go to an emergency room (ER), such as when you have severe chest pain or unstoppable bleeding. At other times, it's less clear. Where do you go when you have an ear infection, or are generally not feeling well? The emergency room is always an option, but it can be an expensive one. You have choices for receiving in-network care that work with your schedule and give you access to the kind of care you need. Know when to use each for non-emergency treatment.

Visit **www.bcbsil.com** for more information or to find a provider.

Care Option	Hours	Your Relative Cost*	Description
MDLIVE	24 hours, seven days a week	$10 copay. This is a lower cost option than an Urgent Care, doctor's office, or ER visit.	MDLIVE provides you access to board-certified doctors immediately or by scheduling an appointment based on your availability for several different health conditions. See "Virtual Visits" on page 17 for more details.
Doctor's Office	Office hours vary	Usually lower out-of-pocket cost to you than urgent care	Your doctor's office is generally the best place to go for non-emergency care such as health exams, colds, flu, sore throats and minor injuries.
Retail Health Clinic**	Similar to retail store hours	Usually lower out-of-pocket cost to you than urgent care	Walk-in clinics are often located in stores and pharmacies to provide convenient, low-cost treatment for minor medical problems like: ear infections, athlete's foot, bronchitis and some vaccinations.
Urgent Care Provider**	Generally include evenings, weekends and holidays	Usually lower cost than an ER visit	Urgent care centers can provide care when your doctor is not available and you don't have a true emergency, but need immediate care. For example, they can treat sprained ankles, fevers, and minor cuts and injuries.
Emergency Room (ER)	24 hours, seven days a week	Highest out-of-pocket cost to you	For medical emergencies, call 911 or your local emergency services first.

*The relative costs described here are for network providers. Your costs for out-of-network providers may be significantly higher

** Not available for HMO Members

If you need emergency care, call 911 or seek help from any doctor or hospital immediately.

VIRTUAL VISITS POWERED BY MDLIVE

JOLIET JUNIOR COLLEGE 1901

FOR PPO MEMBERS

Virtual Visits

Joliet Junior College offers telemedicine services through Blue Cross and Blue Shield of Illinois (BCBSIL) powered by MDLIVE. Whether you're at home or traveling, access to a board-certified doctor is available 24 hours a day, seven days a week. You can speak to a doctor immediately or schedule an appointment based on your availability. Virtual visits can also be a better alternative than going to the emergency room or urgent care center.

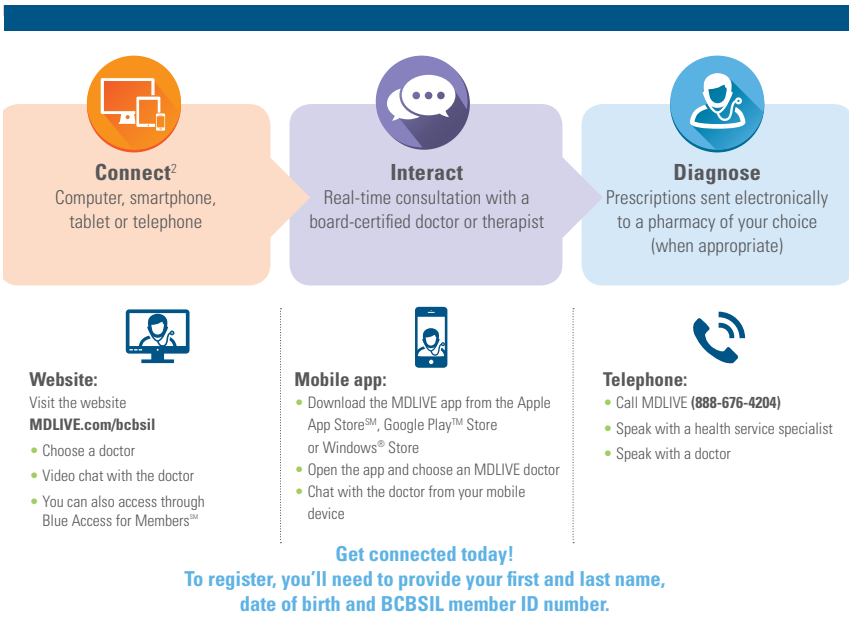
General Health

- Allergies
- Asthma
- Nausea
- Sinus infections

Pediatric Care

- Cold
- Flu
- Ear problems
- Pinkeye

To register, you'll need to provide your first and last name, date of birth and BCBSIL member ID number.



[1] In the event of an emergency, this service should not take the place of an emergency room or urgent care center. MDLIVE doctors do not take the place of your primary care doctor. Proper diagnosis should come from your doctor, and medical advice is always between you and your doctor.

[2] Internet/Wi-Fi connection is needed for computer access. Data charges may apply when using your tablet or smartphone. Check your phone carrier's plan for details. Service is limited to interactive-audio consultations (phone only), along with the ability to prescribe, when clinically appropriate, in Texas. Service is limited to interactive-audio/video (video only), along with the ability to prescribe, when clinically appropriate, in Idaho, Montana, New Mexico and Oklahoma. Virtual visits are currently not available in Arkansas. Service availability depends on member's location. Virtual visits may not be available on all plans.

MDLIVE is not an insurance product nor a prescription fulfillment warehouse. MDLIVE operates subject to state regulations and may not be available in certain states. MDLIVE does not guarantee that a prescription will be written. MDLIVE does not prescribe DEA-controlled substances, non-therapeutic drugs and certain other drugs that may be harmful because of their potential for abuse. MDLIVE physicians reserve the right to deny care for potential misuse of services.

App Store is a service mark of Apple Inc.

Google Play Store is a trademark of Google Inc. ("Google").

Windows is a registered mark of Microsoft™

JOLIET JUNIOR COLLEGE 1901

FOR PPO MEMBERS

Blue Distinction: For hospitals with expertise in specialty care

Blue Distinction is a designation awarded by the Blue Cross and Blue Shield companies to hospitals that have demonstrated expertise in delivering clinically proven specialty healthcare. Its goal is to help consumers find specialty care on a consistent basis, while enabling and encouraging healthcare professionals to improve the overall quality and delivery of care nationwide.

Use the Blue Distinction Center Finder.

- Go to **www.bcbsil.com**
- Select the Provider Finder® tool and search for hospitals
- To find a Blue Distinction center near you, search by designated area of specialty and state

Here are some examples of the Centers of Excellence available to you.

Blue Distinction Centers for Bariatric Surgery®
Provides a full range of bariatric surgical care services, including inpatient care, post-operative care, follow-up and patient education.

Blue Distinction Centers for Cardiac Care®
Provides a full range of cardiac care services, including inpatient cardiac care, cardiac rehabilitation, cardiac catheterization and cardiac surgery.

Blue Distinction Centers for Transplants®
Transplant program that provides services, such as global pricing, financial savings analysis, and global claims administration and support services.

Blue Distinction Centers for Complex and Rare Cancers®
Inpatient cancer care programs for adults, including those treating complex and rare subtypes of cancer, delivered by multidisciplinary teams with subspecialty training and distinguished clinical expertise, focus on treatment planning and complex, major surgical treatments.

Blue Distinction Centers for Knee and Hip Replacement℠
Provides inpatient knee and hip replacement services, including total knee and total hip replacement surgeries.

Blue Distinction Centers for Spine Surgery®
Inpatient spine surgery services, including discectomy, fusion and decompression procedures.

CORE AND BUY-UP DENTAL INSURANCE

JOLIET JUNIOR COLLEGE 1901

Dental

When it comes to the health of your teeth and gums, preventive dental care is important, no matter your age. Semi-annual dental exams and cleanings help to prevent or detect complex conditions such as periodontal surgery, root canals, extractions and fillings to lower your potential financial impact.

The ADA recommends the following steps for good dental health:

- Brush twice a day
- Replace your toothbrush every three or four months
- Floss daily
- Eat a balanced diet and limit sugar intake
- Visit your dentist regularly for dental exams and cleanings

JJC recognizes that different individuals have varying needs in regards to insurance so the College offers a Core Plan and a Buy-Up Plan. It is important that you understand your options and pick accordingly as you will be enrolled in this plan for the year. You can change plans at open enrollment or during a qualifying event.

Blue Cross and Blue Shield of Illinois PPO Plan—offers the luxury and convenience of choice. You choose which dental professionals you and your family see. You can find a provider and look up additional information at **www.bcbsil.com**. If you have any questions regarding claims information, please call **800.367.6401**.

Core Plan		
	In-Network	**Out-of-Network**
Annual Benefit	$1,200 per benefit period	
Annual Deductible (doesn't apply to preventive services)	$25 per person per benefit period $75 maximum per family	
Dependent Coverage	Dependent children are covered to age 26 Eligible military personnel are covered to age 30	
Preventive Services	100%*	100% of usual and customary
Basic Services	100%*	100% of usual and customary
Minor Services	100%*	100% of usual and customary
Periodontic Services **Prosthodontic Services**	50%*	50% of usual and customary
Orthodontics	50%*	50% of usual and customary
Orthodontics Lifetime Limit	$1,000 for eligible dependent children to age 26 only	

Buy-Up Plan		
	In-Network	**Out-of-Network**
Annual Benefit	$2,000 per benefit period	
Annual Deductible (doesn't apply to preventive services)	$25 per person per benefit period $75 maximum per family	
Dependent Coverage	Dependent children are covered to age 26 Eligible military personnel are covered to age 30	
Preventive Services	100%*	100% of usual and customary
Basic Services	100%*	100% of usual and customary
Minor Services	100%*	100% of usual and customary
Periodontic Services **Prosthodontic Services**	50%*	50% of usual and customary
Orthodontics	50%*	50% of usual and customary
Orthodontics Lifetime Limit	$1,500 for adults and eligible dependents to age 26	

*Contracting providers have agreed to accept the Schedule of Maximum Allowances as payment in full for covered services. Non-contracting providers do not accept the Schedule of Maximum Allowances as payment in full. For services received from a non-contracting provider, member will be liable for the difference between the dentist's charge and covered benefits.

YOUR BUNDLED BENEFITS INCLUDE MEDICAL, RX, CORE DENTAL AND CORE VISION

JOLIET JUNIOR COLLEGE 1901

CORE & BUY-UP VISION INSURANCE

YOUR BUNDLED BENEFITS INCLUDE MEDICAL, RX, CORE DENTAL AND CORE VISION

VSP

VSP helps you to keep you and your eyes healthy. As the only national not-for-profit vision care company, VSP helps you:

- **Save money.** Did you know that VSP members get the best value and the lowest out-of-pocket costs, saving them an average of $330 per year?
- **Stay healthy.** Annual eye exams are important to your overall health and can detect chronic conditions, like diabetes and high cholesterol.
- **Look great.** From classic styles to the latest designer frames, you will find hundreds of options for you and your family. Plus, get an extra $20 to spend when you choose a featured frame brand.

Getting Started is a Breeze

- Find the right VSP doctor for you. You'll find plenty to choose from at **www.vsp.com** or by calling **800.877.7195**.
- Already have a VSP doctor? At your appointment, tell them you're a VSP member.
- Check out your coverage and savings. Visit **www.vsp.com** to see your benefits anytime and check out how much you saved with VSP after your appointment.

That's it! VSP will handle the rest—no ID card necessary or claim forms to complete. If you see a non-VSP provider, you will receive a lesser benefit. Before seeing a non-VSP provider, call VSP at **800.877.7195** for more details.

	VSP Base Plan	VSP Buy-Up Plan
Vision Exam	No copay (every 12 months)	$10 copay (every 12 months)
Frames	$200 allowance (every 24 months)	Up to $200 (every 12 months)
Elective Contact Lens (in lieu of glasses)	$200 allowance (every 12 months) Exam: copay (under $60) & 15% off	$200 allowance (every 12 months) Exam: copay (under $60) & 15% off

Buy-Up Plan Additional Benefits

JJC recognizes that different individuals have varying needs in regards to insurance so the College offers a Base Plan and a Buy-Up Plan. It is important that you understand your options and pick accordingly as you will be enrolled in this plan for the year. You can change plans at open enrollment or during a qualifying event.

- $250 Allowance for Frames, Anti-Reflective Lenses, Photochromic Lenses or Progressive Lenses
- Or in lieu of glasses, $250 elective contact lenses allowance plus covered contact lenses exam with copay not to exceed $60

VSP Members Extra Savings and Discounts

- Retail network now includes Walmart, Sam's Club and Costco
- Extra $20 to spend on featured frame brands. Go to **www.vsp.com/offers** for details.
- 20% savings on additional glasses and sunglasses, including lens enhancements, from any VSP provider within 12 months of your last WellVision Exam
- **VSP Diabetic Eyecare Plus Program** - $20 copay per visit
- **Retinal Screening**- No more than a $39 copay on routine retinal screening as an enhancement to a WellVision Exam
- **Laser Vision Correction**- Average 15% off the regular price or 5% off the promotional price; discounts only available from contracted facilities

EMPLOYEE ASSISTANCE PROGRAM (EAP)

JOLIET JUNIOR COLLEGE 1901

Joliet Junior College offers employees, family members and anyone significant to the employee an Employee Assistance Benefits.

Life brings new ups and downs every day. From finding child or elder care or managing your personal finances, to getting help with a relationship or taking care of your health, ComPsych offers **fast, free, confidential help, 24/7.** Call as many times as you want to speak with a caring, Master's level staff clinician with at least 5 years of clinical experience or visit **guidanceresources.com** to find help and resources with almost any issue. No limit to the number of issues per year.

Call ComPsych at 833.962.0004.

You can also visit **www.guidanceresources.com** or download the app, GuidanceNow℠.

WebID: jjceap

The full array of service that you have at no cost, are listed below!

Confidential Emotional Support

Our highly trained clinicians will listen to your concerns and help you or your family members with any issues, including:

- Anxiety, depression, stress
- Grief, loss and life adjustments
- Relationship/marital conflicts

Financial Resources

Everyone has financial questions. With your GuidanceResources benefit, you can get answers to your questions about budgeting, debt management, tax issues and other money concerns from on-staff CPAs, Certified Financial Planners® and other financial experts, simply by calling your toll-free number.

Legal Services

Talk to our attorneys for practical assistance with your most pressing legal issues, including divorce, adoption, family law, wills, trusts and more.

Need representation? Get a free 30-minute consultation and a 25% reduction in fees.

Work-Life Solutions

Our specialists provide qualified referrals and resources for just about anything on your to-do list, such as:

- Finding child and elder care
- Hiring movers or home repair contractors
- Planning events, locating pet care

Online Support

GuidanceResources® Online is your 24/7 link to vital information, tools and support. Log on for:

- Articles, podcasts, videos, slideshows
- On-demand trainings
- "Ask the Expert" personal responses to your questions

WELLNESS

JJC Wellness Works
Feel Well. Do Well.

Wellness Works

Joliet Junior College is serious about wellness and offers employees a variety of resources to help keep them healthy.

- Lunch and Learns
- Benefits/Wellness Fair
- Weight Watchers on Campus
- Yearly Wellness Screenings
- BCBS Members have Well onTarget (see page"Well onTarget®" on page 13)
- Walking Maps/Trails

Fitness Options

- JJC Wellness Fitness Center – Employee fee per semester
- BCBS Members have access to Fitness Program (see page "Blue365" on page 14)

Tobacco-Free Campus Policy

To promote a safe, clean, and healthy learning environment, Joliet Junior College prohibits the use of tobacco products inside College facilities, in all College vehicles and on all College property, except in personal vehicles. This includes the burning of any type of cigar, cigarette, pipe, electronic cigarettes, or any other smoking equipment. The use of smokeless/chewing tobacco is also prohibited. It is the responsibility of all faculty, staff, students and visitors to comply with this policy. Refusal to comply may result in citations issued by the Campus Police Department and/or disciplinary action by the appropriate administrative office. Additional information regarding the Tobacco-Free policy can be found on the Joliet Junior College Portal under the board Policy Manual.

Look for more information from the Benefits Department during the year.

FLEXIBLE SPENDING ACCOUNT

Joliet Junior College offers a Flexible Spending program that allows you to put money into a savings account that you use to pay for certain out-of-pocket health and dependent care costs. Allowable expenses are dictated by Section 125 of the Internal Revenue Code and include deductibles, copays, vision expenses and childcare expenses. The dollars you put into the account are pretax, reducing your taxable income. Please see your Benefits Department for updated IRS annual maximum contribution amounts.

Health FSA

You may elect to put up to the IRS designated annual maximum in the Health FSA; minimum $200.

You can use funds in your FSA to pay for your (or your dependent's) qualified medical, dental, vision, prescription expenses such as deductibles and copayments. You do not need to be enrolled in Joliet Junior College's health plan to enroll in the flexible spending program.

Dependent Care FSA

You may elect to put up to the IRS designated annual maximum in the Dependent Care FSA; minimum $200.

A dependent care flexible spending account allows you to be reimbursed for qualified child care and dependent care expenses using pretax dollars.

Allied Flex Debit Cards — Health FSA Only

The Allied Flex debit card makes using and managing an FSA quick and convenient. In addition, acting as a simple, one-swipe tool that does away with cash copays and claims submission, The Flex Debit Card management page on Allied's secure website allows members to track their Flex account expenses, balances and claims from anywhere, anytime.

Grace Period

Joliet Junior College adopted the IRS grace period rule that will allow you to submit claims that were incurred two and half months after the plan year ends (March 15). This will allow you to use any money left over in your plan year for eligible FSA expenses incurred during the first 2 1/2 months of the plan year.

Claims Submission

Claims can be submitted until March 31 for the plan year. This is a three-month extension to your plan year that will allow you to submit expenses incurred prior to the end of your plan year.

Use It Or Lose It

Section 125 of the Internal Revenue Code requires that any money left in the account at the end of the plan year, after the grace period has been applied and exhausted, will revert back to the plan.

Allied Flex Benefit Systems, Inc.
200 W. Adams Street, Suite 500
Chicago, IL 60606

Allied Customer Service: 312.906.8080
email: flexClaims@alliedbenefit.com
Fax: 312.416.2870

Obtain reimbursement forms and other information at: **www.alliedbenefit.com/forms-fsa.aspx**

BASIC AND VOLUNTARY LIFE AND AD&D INSURANCE

JOLIET JUNIOR COLLEGE has an array of additional benefits that are available to you through Reliance Standard! Don't forget to utilize these great products!

JOLIET PROVIDED BENEFITS– AT NO COST TO YOU!

BASIC LIFE AND AD&D INSURANCE

Joliet Junior College provides Basic Life and AD&D coverage to each active, full-time employee at no cost. The Life coverage pays a sum of money at the death of the insured person and the AD&D policy pays benefits to the beneficiary if the cause of death is an accident.

TRAVEL ASSISTANCE

Travel Assistance is included with the AD&D Insurance. When traveling more than 100 miles from home, you receive travel assistance services provided by On Call International. Please call 800.456.3893 (in the U.S. toll-free) or 603.328.1966 (worldwide, collect) to provide you with a range of information, referral, coordination, and arrangement services designed to respond to most emergencies you may encounter when you travel. There are an array of support services before, during and after your travels.

BEREAVEMENT COUNSELING

Bereavement Counseling is included with the Term Life Insurance. Losing someone can cause painful and emotional feelings. You may benefit from the assistance of talking with a professional counselor experienced in dealing with grief and loss. We have a 24/7 toll-free counseling service for all household members at 855.775.4357. All requests for any assistance or information shared is kept strictly confidential.

IDENTITY THEFT RESTORATION

To protect you and your family from this devastating loss of time, money and security, you have a full service Identity Recovery Program that will perform the recovery process for you should you or a member of your family fall victim to identity theft. Call toll free to **855.246.7347** if you suspect your personal information has been compromised. You also have access to real-time card monitoring through WalletArmor®. Which is an interactive, easy-to-use vault for protecting your wallet's contents, passwords and important personal documents. Enroll in WalletArmor® today at **www.reliancestandard.com/walletarmor.**

ADDITIONAL BENEFITS – EMPLOYEE PAID

SUPPLEMENTAL LIFE AND AD&D INSURANCE

Each active, full-time employee is eligible to enroll in this Supplemental Life and AD&D coverage. **Employee and Spouse** coverage is from $10,000 to $750,000 in increments of $10,000. Newly eligible employees have a guaranteed issue amount up to $150,000, no medical questions required. An election over the guarantee issue amount, or when electing coverage when not first eligible, will require you to complete evidence of insurability, medical questions. **Employee** coverage may not exceed 7 times annual salary, and **Spouse** may not exceed the Employee's coverage amount.

Spouse insurance can not exceed 100% of the employee's coverage amount (minimum coverage amount $10,000). Newly eligible spouses are guaranteed up to $100,000 in coverage. An election over the guarantee issue amount, or when electing coverage when not first eligible, will require you to complete evidence of insurability, medical questions.

Child coverage is offered at $2,500, $5,000, $7,500, or $10,000. Employees can purchase dependent insurance for child(ren) age 14 days up to 26 years. Dependent child(ren) AD&D insurance cannot exceed 10% of the employee's elected coverage amount. Dependent children life coverage at any amount is guarantee issue. Additional benefits include Accelerated Death Benefit, Living Benefit Rider, and Bereavement Counseling.

- New Hires Guarantee Issue – no medical exam required
- Waiver of Premium – premiums are waived if you should become totally disabled
- Portable – keep insurance if you later become ineligible
- Conversion Privilege – you can convert your coverage to an individual insurance policy without having to furnish proof of good health

This AD&D coverage is a convenient, affordable measure of protection for you and your family against the very aspects of life no one wants to think about, let alone plan for. This coverage is convertible and includes Exposure & Disappearance Coverage, Reserve National Guard Benefit, and Seat Belt/Air Bag Benefit.

Monthly Premium Rates

Employee/Spouse Age (rate will age annually on January 1)	Rate Per $10,000 of Coverage
Under age 30	$.67
30-39	$.86
40-44	$1.33
45-49	$2.00
50-54	$3.14
55-59	$5.13
60-64	$8.17
65-69	$12.83
70 and over	$26.00

*You are automatically enrolled in AD&D insurance upon election of Life insurance. Premium amount is included in the above rate.

Dependent Child(ren)	Rate
$2,500	$0.55
$5,000	$1.10
$7,500	$1.65
$10,000	$2.20

*One rate for all eligible dependent children in the family regardless of the number.

JOLIET JUNIOR COLLEGE 1901

VOLUNTARY LONG-TERM DISABILITY INSURANCE

VOLUNTARY LONG-TERM DISABILITY BENEFIT

This Voluntary LTD program is a supplement to your SURS gap to 65% benefit (non-tax) until the age of 65. Each active, full-time employee earning an annual salary of at least $10,000 is eligible for this coverage. Included is a Survivor Benefit and Conversion Privilege. Newly eligible employees can add LTD without evidence of insurability during their first 31 days of employment.

Does the Plan Limit Benefits?

It is subject to a Pre-existing Condition Limitation of 6/6/24 that states that a preexisting condition is any condition for which you...

- 6 Months – received treatment in the 6 months immediately prior to coverage effective date
- 6 Months – received in the 6 months immediately following effective date
- 24 Months – are receiving ongoing treatment

Who is Eligible?

Each active, full-time employee working 40 or more hours per week, except any person working on a temporary or seasonal basis is eligible to purchase Voluntary Long-Term Disability Insurance.

What is a Disability? How is it Defined?

- Regular ("own") occupation
- Any occupation

Totally Disabled means that as a result of an injury or sickness, during the Elimination Period and for the first 60 months, you cannot perform the material duties you routinely performed for your employer.

"Regular ("own") occupation" means that you cannot perform the occupation you are routinely performing. We will look at your occupation as it is normally performed in the national economy, and not how the work tasks are performed for a specific employer or at a specific location.

"Any occupation" means that you cannot perform any occupation normally performed in the national economy for which you are reasonably suited based upon your education, training or experience. The "any occupation" definition applies for the remainder of the disability. That means from the end of the own job" and/or "own occupation" period up to the maximum benefit duration period.

Reliance Standard considers you to be disabled during and after the elimination period if, because of injury or sickness, you cannot perform the material duties of your "own occupation" or "any occupation" (as applicable) on a part-time basis, or some of the material duties full-time."Total" disability is not required.

What is the Benefit Amount?

The Long-Term Disability benefit replaces a portion of your pre-disability monthly earnings, less the income that was actually paid to you for the same Disability from other sources (e.g., SURS, Social Security, etc.). The benefit amount is 65% of your pre-disability monthly earnings up to a maximum of $8,000 with a minimum of $100.

When do Benefits Begin and How Long do they Continue?

Benefits begin after the end of the elimination period. The elimination period begins on the day you become disabled and is the length of time you must wait while being disabled before you are eligible to receive a benefit. Your elimination period for Long Term Disability is 90 days. The benefit duration period (amount of time benefits can be paid) extends to a person's normal retirement age as defined by the 1983 amendments to the United States Social Security Act. All duration schedules comply with the Age Discrimination and Employment Act (ADEA). If you recover from your disability, you will also no longer receive benefits.

What does the State Universities Retirement System (SURS) Disability Plan Pay if I'm Disabled?

You may claim SURS disability benefits if, after you have at least two years of service credit, you become unable to perform your job due to illness. There is no minimum service credit required to claim SURS disability benefits if you are disabled due to an accident. SURS benefits begin on the later of 1) the day following 60 continuous calendar days of disability, or 2) the day following your last day of employer-provided salary or sick leave payments.

The amount of SURS disability benefit will be the greater of 1) 50% of your basic compensation on the day you became disabled or, 2) 50% of your average earnings for the 24 months prior to the date you became disabled.

The SURS disability benefit is taxable. It is paid until you have received 50% of your earnings while a participant of SURS. You must requalify for the 35% Disability Retirement Allowance (DRA) which is also taxable. To qualify, you must be unable to perform any gainful occupation (for additional information, see your SURS Member Guide).

The voluntary long-term disability benefit is tax-free and supplements SURS or DRA if they pay and pays a benefit when SURS does not pay, providing you qualify for disability. It may pay in the case of partial disability.

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STATE UNIVERSITIES RETIREMENT SYSTEM (SURS) HIGHLIGHTS

Sample SURS Employee

Name: Male age 45, disabled due to an illness

Annual Salary: $60,444

Monthly Salary: $5,037

Months of Employment: 48 months

State Universities Retirement System: 50% (before tax) of monthly salary up to 50% of total SURS earnings.

(SURS) Monthly Disability Benefit: Two years of SURS service credit is required to be eligible, and benefits commence the later of exhaustion of sick days or 60-day elimination period ($2,518.50 payable until you've received 50% of your earnings under SURS).

Disability Retirement Allowance (DRA) Monthly Disability Benefit: 35% (before tax) of monthly salary to age 65 ($1,762.95 payable to age 65 assuming continuation of total disability).

Reliance Standard Disability Benefit: 65% (tax-free) of salary to age 65 after your elimination period, the greater of 90 days or your accumulated sick leave ($3,274 payable monthly to age 65 offset by SURS or DRA, if payable).

Employee becomes totally disabled but then partially recovers and does not qualify for DRA benefits. SURS pays 50% (before tax) of salary for approximately 2½ years then benefits end because the employee doesn't qualify for DRA continuation.

Reliance Standard supplements the SURS payment up to 65% (tax-free) of pre-disability salary then continues up to Social Security Normal Retirement Age with a partial disability benefit.

Age	Monthly Rate Per $100 of Covered Benefit
18-24	$0.152
25-29	$0.167
30-34	$0.182
35-39	$0.198
40-44	$0.274
45-49	$0.404
50-54	$0.579
55-59	$0.732
60-64	$0.755
65-69	$0.870
70 and over	$1.160

Once you are deemed to be eligible for SURS participation, eight percent (8%) of your gross earnings including earnings for overtime and summer sessions is automatically deducted from your paycheck. Police officers have special rules that allow them to contribute 9.5% of gross earnings. Full-time community college employees pay an additional 0.5% of earnings to fund a health insurance plan devised for community college retirees.

The contributions you make to SURS will not be subject to Federal taxes until you begin to withdraw funds following your retirement. An employee who first becomes a SURS member (or other eligible Illinois reciprocal system) on or after 1/1/2011 is considered a Tier 2 member under the retirement plan. Please note SURS Members do not participate in Social Security.

SURS Retirement Plans Options:

The State Universities Retirement System of Illinois (SURS) provides retirement, disability, death, and survivor benefits to eligible SURS participants and annuitants. SURS members must choose one of three retirement options; the Traditional Benefit Package, the Portable Benefit Package, or the Self-Managed Plan (SMP).

SURS will send an information packet directly to your home within approximately 4–6 weeks after your initial SURS eligibility date. You have six months from your initial date of eligibility to select one of three retirement plans; and return your election form to SURS. The choice is permanent and cannot be changed. If a new member fails to choose within six months, they will be permanently enrolled in the Traditional Benefit Package.

For additional information, call **800.275.7877** (**800.ASK.SURS**) or **www.SURS.org.**

403(b) and 457(b) Retirement Plans

Joliet Junior College offers traditional, and 403(b) and 457(b) deferred compensation plans, providing you the opportunity to accumulate money for retirement. You can contribute pretax or post-tax dollars to both plans automatically through payroll deduction, which may lower current income taxes. Your accounts benefit from tax-advantaged growth.

For more information, please contact:

TSA Consulting Group, Inc.
28 Ferry Road, SE
Fort Walton Beach, FL 32548

850.362.6840 or 888.796.3786 (toll free)

www.tsacg.com

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GLOSSARY OF EMPLOYEE BENEFIT TERMS

Allowed Amount. Maximum amount on which payment is based for covered healthcare services. This may be called "eligible expense," "payment allowance" or "negotiated rate." If your provider charges more than the allowed amount, you may have to pay the difference. (See Balance Billing.)

Balance Billing. When a provider bills you for the difference between the provider's charge and the allowed amount. For example, if the provider's charge is $100 and the allowed amount is $70, the provider may bill you for the remaining $30. A preferred provider should not balance bill you.

Beneficiary. The person(s) you name to receive certain benefits (such as life insurance) upon your death.

Brand Name Drug: Medications are marketed under a trademark-protected name and are often available from only one manufacturer.

Coinsurance. The percentage of covered medical or dental expenses that you must pay. For example, if your plan pays 80%, you must pay the remaining 20%.

Copayment. A fixed amount you pay for a covered healthcare service, usually at the time of service.

Deductible. The amount of medical or dental expenses you must pay each year before your plan begins paying benefits.

Deductible Carryover. In some benefit plans, not Health Savings Account Compatible Plans, if you have not met your annual deductible during the last three months of the plan year the claims incurred may apply toward the deductible for the next plan year.

Emergency Medical Condition. An illness, injury, symptom or condition so serious that a reasonable person would seek care right away to avoid severe harm.

Evidence of Insurability (EOI). An application process in which you provide information on the condition of your health or your dependent's health in order to be considered for certain types of insurance coverage.

Explanation of Benefits (EOB). The document you receive from the insurance company after your claim is filed and processed. The EOB shows how much of the expense the plan covered and how much you may be expected to pay.

Formulary Brand Name Drug: A list of prescribed medications that are preferred by your plan because they are safe, effective alternatives to other generics or brands that may be more expensive. The formulary has a wide selection of generic and brand-name medications.

HIPAA (Health Insurance Portability and Accountability Act of 1996). A federal law that addresses the privacy of patient health information. The "privacy" regulations give patients greater access to their own medical records and more control over how their personal health information is used. Also, the law defines the obligations of healthcare providers and health plans to protect patient records.

Hospitalization. Care in a hospital that requires admission as an inpatient and usually requires an overnight stay.

Hospital Outpatient Care. Care in a hospital that doesn't require an overnight stay.

In-Network Provider. The facilities, providers and suppliers your health insurer or plan has contracted with to provide healthcare services.

Maximum annual benefit. The maximum amount the plan pays for specific services (such as dental or chiropractic) for a covered individual, each plan year.

Medically necessary. Services and supplies that the insurance company determines to be consistent with generally accepted practices for the diagnosis of an illness or injury, or the medical care of a diagnosed illness or injury. Only medically necessary services and supplies are covered by the plan.

Out-of-Network Provider. The facilities, providers and suppliers who don't have a contract with your health insurer or plan to provide services to you. You'll pay more to see an out-of-network provider.

Out-of-Pocket Limit. Is the most you have to pay for covered medical expenses in a year. Once you've reached the out-of-pocket maximum, the plan pays 100% of eligible expenses for the remainder of the plan year. This limit never includes your premium, balance-billed charges or charges the plan doesn't cover.

Plan. A benefit your employer, or other group sponsor provides to you to pay for your healthcare services.

Plan year. The period of time in which plan coverage and records are based. For the District's plan, it is the calendar year. (For example, the annual deductible, annual out-of-pocket maximum, and maximum annual benefit all apply to expenses incurred during the plan year.)

Preauthorization. A decision by your health insurer or plan that a healthcare service, treatment plan, prescription drug or durable medical equipment is medically necessary. Sometimes called prior authorization, prior approval or precertification.

Premium. The amount you pay for your healthcare coverage and other benefits, through payroll deductions.

Primary Care Physician. A physician who provides both the first contact for a person with an undiagnosed health concern as well as continuing care of varied medical conditions, not limited by cause, organ system, or diagnosis. The following types of providers are PCPs: family practitioners, general practitioners, pediatricians, internal medicine, and gynecologists.

Specialist. A physician specialist focuses on a specific area of medicine or a group of patients to diagnose, manage, prevent or treat certain types of symptoms and conditions.

Urgent Care. Care for an illness, injury or condition serious enough that a reasonable person would seek care right away, but not so severe as to require emergency room care.

Voluntary benefits. Optional benefit plans sponsored by the employer, but fully paid for by employees who elect coverage. These benefits are generally available at special group rates or discounts, making them more cost-effective than employees could obtain on their own.

Waiver of Premium. Rider or provision included in the life insurance policy exempting the insured from paying premiums after insured has been disabled for a specified period of time.

General Notice Of COBRA Continuation Coverage Rights
Continuation Coverage Rights Under COBRA

Introduction

You're getting this notice because you recently gained coverage under a group health plan (the Plan). This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it.** When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end. For more information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

What is COBRA continuation coverage?

COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you're an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you're the spouse of an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because of the following qualifying events:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;

- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Plan as a "dependent child."

When is COBRA continuation coverage available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. The employer must notify the Plan Administrator of the following qualifying events:

- The end of employment or reduction of hours of employment;
- Death of the employee;
- The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. You must provide this notice to: Joliet Junior College – Human Resources – 1215 Houbolt Road, Joliet IL 60404.

How is COBRA continuation coverage provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

There are also ways in which this 18-month period of COBRA continuation coverage can be extended:

Disability extension of 18-month period of COBRA continuation coverage

If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage.

Second qualifying event extension of 18-month period of continuation coverage

If your family experiences another qualifying event during the 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the Plan is properly notified about the second qualifying event. This extension may be available to the spouse and any dependent children getting COBRA continuation coverage if the employee or former employee dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); gets divorced or legally separated; or if the dependent child stops being eligible under the Plan as a dependent child. This extension is only available if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

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Are there other coverage options besides COBRA Continuation Coverage?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at **www.healthcare.gov**.

If you have questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit **www.dol.gov/ebsa**. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit **www.HealthCare.gov**.

Keep your plan administrator informed of address changes

To protect your family's rights, let the Plan Administrator know about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Plan contact information

Allied
200 W. Adams St. Suite 500
Chicago, IL 60606
312.906.8080

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

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit **www.healthcare.gov**.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a state listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are **not** currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **877.KIDS.NOW** or **www.insurekidsnow.gov** to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and you must request coverage within 60 days of being determined eligible for premium assistance. If you have questions about enrolling in your employer plan, contact the Department of Labor at **www.askebsa.dol.gov** or call **866.444.EBSA (3272)**.

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2019. Contact your state for more information on eligibility.

ALABAMA – Medicaid
http://myalhipp.com 855.692.5447
ALASKA – Medicaid
The AK Health Insurance Premium Payment Program http://myakhipp.com/ | 866.251.4861 CustomerService@MyAKHIPP.com Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx
ARKANSAS – Medicaid
http://myarhipp.com 855.MyARHIPP (855.692.7447)
COLORADO – Medicaid and CHIP
Health First Colorado (Colorado's Medicaid Program) https://www.healthfirstcolorado.com Member Contact Center: 800.221.3943 | State Relay 711 Child Health Plan Plus (CHP+) Colorado.gov/HCPF/Child-Health-Plan-Plus Customer Service: 800.359.1991 | State Relay 711
FLORIDA – Medicaid
http://flmedicaidtplrecovery.com/hipp 877.357.3268
GEORGIA – Medicaid
http://dch.georgia.gov/medicaid Click on Health Insurance Premium Payment (HIPP) 404.656.4507

INDIANA – Medicaid
Healthy Indiana Plan for low-income adults 19-64 http://www.in.gov/fssa/hip/ | 877.438.4479 All other Medicaid http://www.indianamedicaid.com | 800.403.0864
IOWA – Medicaid
http://dhs.iowa.gov/hawk-i 800.257.8563
KANSAS – Medicaid
http://www.kdheks.gov/hcf 785.296.3512
KENTUCKY – Medicaid
http://chfs.ky.gov 800.635.2570
LOUISIANA – Medicaid
http://dhh.louisiana.gov/index.cfm/subhome/1/n/331 888.695.2447
MAINE – Medicaid
http://www.maine.gov/dhhs/ofi/public-assistance/index.html 800.442.6003 | TTY: Maine relay 711
MASSACHUSETTS – Medicaid and CHIP
http://www.mass.gov/eohhs/gov/departments/masshealth 800.862.4840
MINNESOTA – Medicaid
http://mn.gov/dhs/people-we-serve/seniors/health-care/health-care-programs/programs-and-services/other-insurance.jsp 800.657.3739

MISSOURI – Medicaid
http://www.dss.mo.gov/mhd/participants/pages/hipp.htm 573.751.2005
MONTANA – Medicaid
http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP 800.694.3084
NEBRASKA – Medicaid
http://www.ACCESSNebraska.ne.gov Phone: 855.632.7633 | Lincoln: 402.473.7000 | Omaha: 402.595.1178
NEVADA – Medicaid
http://dwss.nv.gov 800.992.0900
NEW HAMPSHIRE – Medicaid
https://www.dhhs.nh.gov/ombp/nhhpp/ Phone: 603.271.5218 Hotline: NH Medicaid Service Center at 888.901.4999
NEW JERSEY – Medicaid and CHIP
Medicaid: http://www.state.nj.us/humanservices/dmahs/clients/medicaid 609.631.2392 CHIP: http://www.njfamilycare.org/index.html 800.701.0710
NEW YORK – Medicaid
https://www.health.ny.gov/health_care/medicaid/ 800.541.2831
NORTH CAROLINA – Medicaid
https://dma.ncdhhs.gov 919.855.4100
NORTH DAKOTA – Medicaid
http://www.nd.gov/dhs/services/medicalserv/medicaid 844.854.4825
OKLAHOMA – Medicaid and CHIP
http://www.insureoklahoma.org 888.365.3742
OREGON – Medicaid
http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html 800.699.9075
PENNSYLVANIA – Medicaid
http://www.dhs.pa.gov/provider/medicalassistance/healthinsurancepremiumpaymenthippprogram/index.htm 800.692.7462
RHODE ISLAND – Medicaid
http://www.eohhs.ri.gov 855.697.4347
SOUTH CAROLINA – Medicaid
http://www.scdhhs.gov 888.549.0820
SOUTH DAKOTA – Medicaid
http://dss.sd.gov 888.828.0059

TEXAS – Medicaid
http://gethipptexas.com 800.440.0493
UTAH – Medicaid and CHIP
Medicaid: https://medicaid.utah.gov CHIP: http://health.utah.gov/chip 877.543.7669
VERMONT – Medicaid
http://www.greenmountaincare.org 800.250.8427
VIRGINIA – Medicaid and CHIP
Medicaid: http://www.coverva.org/programs_premium_assistance.cfm 800.432.5924 CHIP: http://www.coverva.org/programs_premium_assistance.cfm 855.242.8282
WASHINGTON – Medicaid
http://www.hca.wa.gov/free-or-low-cost-health-care/program-administration/premium-payment-program 800.562.3022, ext. 15473
WEST VIRGINIA – Medicaid
http://mywvhipp.com/ 855.MyWVHIPP (855.699.8447)
WISCONSIN – Medicaid and CHIP
https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf 800.362.3002
WYOMING – Medicaid
https://wyequalitycare.acs-inc.com 307.777.7531

To see if any other states have added a premium assistance program since July 31, 2019, or for more information on special enrollment rights, contact either:

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

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
877.267.2323, Menu Option 4, Ext. 61565

OMB Control Number 1210-0137 (expires 12/31/19)

Women's Health & Cancer Rights Act

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

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

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under the plan.

If you would like more information on WHCRA benefits, call Blue Cross Blue Shield of Illinois.

HIPAA Notice of Privacy Practices

Your Information. Your Rights. Our Responsibilities.

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. **Please review it carefully.**

Your Rights

You have the right to:

- Get a copy of your health and claims records
- Correct your health and claims records
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

Your Choices

You have some choices in the way that we use and share information as we:

- Answer coverage questions from your family and friends
- Provide disaster relief
- Market our services and sell your information

Our Uses and Disclosures

We may use and share your information as we:

- Help manage the healthcare treatment you receive
- Run our organization
- Pay for your health services
- Administer your health plan
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests and work with a medical examiner or funeral director
- Address workers compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get a copy of health and claims records

- You can ask to see or get a copy of your health and claims records and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health and claims records, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct health and claims records

- You can ask us to correct your health and claims records if you think they are incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will consider all reasonable requests, and must say "yes" if you tell us you would be in danger if we do not.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations.
- We are not required to agree to your request, and we may say "no" if it would affect your care.

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and healthcare operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

- You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information on page 1.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20211, calling **877.696.6775**, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/**.
- We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in payment for your care
- Share information in a disaster relief situation

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we never share your information unless you give us written permission:

- Marketing purposes
- Sale of your information

Our Uses and Disclosures

How do we typically use or share your health information?
We typically use or share your health information in the following ways.

Help manage the healthcare treatment you receive
We can use your health information and share it with professionals who are treating you.

Example: A doctor sends us information about your diagnosis and treatment plan so we can arrange additional services.

Run our Organization

- We can use and disclose your information to run our organization and contact you when necessary.
- We are not allowed to use genetic information to decide whether we will give you coverage and the price of that coverage. This does not apply to long term care plans.

Example: We use health information about you to develop better services for you.

Pay for Your Health Services

We can use and disclose your health information as we pay for your health services.

Example: We share information about you with your dental plan to coordinate payment for your dental work.

Administer Your Plan

We may disclose your health information to your health plan sponsor for plan administration.

Example: Your company contracts with us to provide a health plan, and we provide your company with certain statistics to explain the premiums we charge.

How else can we use or share your health information?
We are allowed or required to share your information in other ways—usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information, see **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html**.

Help With Public Health and Safety Issues

We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do Research

We can use or share your information for health research.

Comply With the Law

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests and work with a medical examiner or funeral director

- We can share health information about you with organ procurement organizations.
- We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address Workers Compensation, Law Enforcement, and Other Government Requests

We can use or share health information about you:

- For workers compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to Lawsuits an Legal Actions

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.**

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request.

JOLIET JUNIOR COLLEGE 1901

HIPAA Special Enrollment Rights

Joliet Junior College's

Initial Notice of Your HIPAA Special Enrollment Rights

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

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

Loss of Other Coverage (Excluding Medicaid or a State Children's Health Insurance Program). If you decline enrollment for yourself or for an eligible dependent (including your spouse) while other health insurance or group health plan coverage is in effect, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

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

New Dependent by Marriage, Birth, Adoption, or Placement for Adoption. If you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your new dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

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

To request special enrollment or to obtain more information about the plan's special enrollment provisions, contact Human Resources at **815.280.2428**.

Certificates of Creditable Drug Coverage

Important Notice from JJC About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Joliet Junior 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. Joliet Junior College has determined that the prescription drug coverage offered by the Joliet Junior 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 15 to December 7.

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 Joliet Junior College coverage will not be affected.

If you do decide to join a Medicare drug plan and drop your current Joliet Junior College coverage, be aware that you and your dependents will not be able to get this coverage back until the following annual enrollment or if you experience a qualifying event.

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 Joliet Junior 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.

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Discrimination is Against the Law

Joliet Junior College complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Joliet Junior College does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Joliet Junior College:

- Will guide you to free aids and services to people with disabilities to communicate effectively with us, such as:
  - » Qualified sign language interpreters
  - » Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Will guide you to free language services to people whose primary language is not English, such as:
  - » Qualified interpreters
  - » Information written in other languages

If you need assistance with these services, contact Patty Sanchez.

If you believe that Joliet Junior College has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Patty Sanchez, Employee Benefits/Training Specialist, 1215 Houbolt Rd., Joliet, IL, 60431, Phone: **815.280.2428**, Fax: **815.280.2400**, **psanchez@jjc.edu**. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Patty Sanchez, Employee Benefits/Training Specialist is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf**, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SWRoom 509F, HHH Building

Washington, D.C. 20211

1.800.368.1019, **800.537.7697** (TDD)

Complaint forms are available at **http://www.hhs.gov/ocr/office/file/index.html**.

Translated Resources

Under Section 1557 of the Affordable Care Act (ACA), covered entities are required to post notices of nondiscrimination and taglines that alert individuals with limited English proficiency (LEP) to the availability of language assistance services. The translated resources below are the **top 15 languages used in Illinois** and are available for use by JJC.

(Spanish) ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1.877.696.6775.

(Polish) UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1.877.696.6775.

(Chinese) 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1.877.696.6775

(Korean) □□: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1.877.696.6775 번으로 전화해 주십시오.

(Tagalog) PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1.877.696.6775.

(Arabic) ملحوظة: إذا كنت تتحدث اللغة العربية، فإن خدمات المساعدة اللغوية متاحة لك بالمجان. اتصل بالرقم 1.877.696.6775.

(Russian) ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1.877.696.6775.

(Gujarati) સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો 1.877.696.6775.

(Urdu) خبردار: اگر آپ اردو بولتے ہیں، تو آپ کو زبان کی مدد کی خدمات مفت میں دستیاب ہیں - کال کریں 1.877.696.6775.

(Vietnamese) CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1.877.696.6775.

(Italian) ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1.877.696.6775.

(Hindi) ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1.877.696.6775. पर कॉल करें।

(French) ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1.877.696.6775.

(Greek) ΠΡΟΣΟΧΗ: Αν μιλάτε ελληνικά, στη διάθεσή σας βρίσκονται υπηρεσίες γλωσσικής υποστήριξης, οι οποίες παρέχονται δωρεάν. Καλέστε 1.877.696.6775.

(German) ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1.877.696.6775.

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New Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMB No. 1210-0149
(expires 5-31-2020)

PART A: General Information

When key parts of the health care law take effect in 2014, there will be a new way to buy health insurance: the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace and employment-based health coverage offered by your employer.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins in October 2013 for coverage starting as early as January 1, 2014.

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

You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5% of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.[1]

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

How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description or contact Human Resources Department.

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit HealthCare.gov for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

[1] An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs.

PART B: Information About Health Coverage Offered by Your Employer

This section contains information about any health coverage offered by your employer. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information. This information is numbered to correspond to the Marketplace application.

3. Employer name Joliet Junior College		4. Employer Identification Number (EIN) 510176990
5. Employer address 1215 Houbolt Road		6. Employer phone number 815.729.9020
7. City Joliet	8. State IL	9. ZIP code 60431
10. Who can we contact about employee health coverage at this job? Human Resources Department		
11. Phone number (if different from above) 815.280.2266	12. Email address hr@jjc.edu	

Here is some basic information about health coverage offered by this employer:

- As your employer, we offer a health plan to:
  - ☐ All employees. Eligible employees are:
  - ☐ Some employees. Eligible employees are:
- With respect to dependents:
  - ☐ We do offer coverage. Eligible dependents are:
  - ☐ We do not offer coverage.

☐ If checked, this coverage meets the minimum value standard, and the cost of this coverage to you is intended to be affordable, based on employee wages.

** Even if your employer intends your coverage to be affordable, you may still be eligible for a premium discount through the Marketplace. The Marketplace will use your household income, along with other factors, to determine whether you may be eligible for a premium discount. If, for example, your wages vary from week to week (perhaps you are an hourly employee or you work on a commission basis), if you are newly employed mid-year, or if you have other income losses, you may still qualify for a premium discount.

If you decide to shop for coverage in the Marketplace, **HealthCare.gov** will guide you through the process. Here's the employer information you'll enter when you visit **HealthCare.gov** to find out if you can get a tax credit to lower your monthly premiums.

The information below corresponds to the Marketplace Employer Coverage Tool. Completing this section is optional for employers, but will help ensure employees understand their coverage choices.

13. **Is the employee currently eligible for coverage offered by this employer, or will the employee be eligible in the next 3 months?**

☐ **Yes** (Continue)
13a. If the employee is not eligible today, including as a result of a waiting or probationary period, when is the employee eligible for coverage?_____ (mm/dd/yyyy) (Continue)
☐ **No** (STOP and return this form to employee)

14. Does the employer offer a health plan that meets the minimum value standard*?
☐ Yes (Go to question 15) ☐ No (STOP and return form to employee)

15. For the lowest-cost plan that meets the minimum value standard* **offered only to the employee** (don't include family plans): If the employer has wellness programs, provide the premium that the employee would pay if he/ she received the maximum discount for any tobacco cessation programs, and didn't receive any other discounts based on wellness programs.
a. How much would the employee have to pay in premiums for this plan? $_____
b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Quarterly ☐ Yearly

If the plan year will end soon and you know that the health plans offered will change, go to question 16. If you don't know, STOP and return form to employee.

16. What change will the employer make for the new plan year?_____
☐ Employer won't offer health coverage
☐ Employer will start offering health coverage to employees or change the premium for the lowest-cost plan available only to the employee that meets the minimum value standard.* (Premium should reflect the discount for wellness programs. See question 15.)
a. How much would the employee have to pay in premiums for this plan? $_____
b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Quarterly ☐ Yearly

• An employer–sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs (Section 36B(c)(2)(C)(ii) of the Internal Revenue Code of 1986)

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This benefit summary prepared by

Gallagher

Insurance | Risk Management | Consulting

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My JJC Benefits

2019 Open Enrollment for Benefit Changes Effective 1/1/20

Open Enrollment is from November 1, 2019 to November 17, 2019.

Please remember that Open Enrollment is your only chance to add or make changes during the year to your benefits without a qualifying life event. All changes are effective January 1, 2020. This is a PASSIVE enrollment, which means that your benefits (except flex spending) will stay the same unless you actively make changes. We strongly encourage you to use this time to ensure that you have all the benefits you need for you and your family. You can access the open enrollment information via the My JJC portal under the Benefits Enrollment Tab.

BENEFIT HIGHLIGHTS

MEDICAL

Blue Cross Blue Shield of Illinois (group number is P14491) PPO

Blue Cross Blue Shield of Illinois (group number 014491) HMO

During open enrollment, you may change, add or delete qualified dependents or enroll in either of the medical plans. Use the Open enrollment form changes.

- **The open enrollment form is a fillable form that once completed you save for your records and send to HRBenefits@jjc.edu.**
- If you are adding dependents, you will need to bring a copy of the birth certificate and a copy of social security card along with your enrollment form to Human Resources. If you are adding a spouse, you will also need to bring a copy of the marriage certificate.
- If you are switching to an HMO, you will need to enter the HMO Medical Group #-number and Primary Care Physician Number (PCP). Directions on how to find a doctor are included on the portal. You can also call 1-800-892-2803 to obtain the PCP and Medical Group information.

HMO members wishing to make changes to their PCP must contact BCBS directly, using the number provided on your ID card.

PRESCRIPTION (RX)

This is a benefit that is bundled with your medical insurance.

- PPO members have the prescription program through Express Scripts (you will receive a separate ID card from Express Scripts)
- HMO members have the prescription program through Prime Therapeutics (you will use the same ID card from BCBS that you use for your medical coverage)

DENTAL

Our basic dental benefits which are bundled also with your medical are provided through BC/BS. Employees may be satisfied with the included coverage or you may purchase the additional dental buy-up plan. Please present the dental card you were issued to your provider for services. The benefit highlights are on the portal for comparison purposes. Fill out the enrollment form for the dental buy up plan if you want to change/add coverage for 2018. The plans are outlined below:

Core Plan	(group #P14491)	provided at no cost to the employee is coverage up to $1,200 per benefit period (per person covered on your plan). Orthodontics for eligible dependent children up to age 26
Buy-Up Plan	(group #P14492)	Additional cost to increase the yearly allowable limit to $2,000 per benefit period (per person covered on your plan). Orthodontics include both adults and eligible dependents

Buy up Plan Monthly Cost: Single $9.25 Family $23.50

Use the open enrollment form for changes

VISION

Our vision included with medical is provided thru VSP. New this year is a buy up option that allows you to have access to either glasses or contact lenses for you and your family every year. If you want the buy up options you will need to add this year. **See VSP Highlights** on our portal for additional information.

Vision Buy up Monthly cost Single $3.12 Family $7.81

Use the open enrollment form for changes

BASIC LIFE INSURANCE - Joliet Junior College provides Basic Life and AD&D coverage to each active, full-time employee at no cost.

OPTIONAL SUPPLEMENTAL LIFE INSURANCE

Each active, full-time employee is eligible to enroll in this Supplemental Life and AD&D coverage. Employee and Spouse coverage is from $10,000 to $750,000 in increments of $10,000. Employee coverage may not exceed 7 times his/her annual salary, and Spouse coverage may not exceed the Employee's coverage amount. Child coverage is offered at $2,500, $5,000, $7,500, or $10,000. During this open enrollment, you will be able to choose $10,000 without Evidence of Insurability (EOI). Anything above $10,000 will require you to fill out EOI. If you have $150,000 or over that amount, you can still take advantage of the additional $10,000. **REQUEST EOI FORM FROM HUMAN RESOURCES**.

- Remember that Optional life is age banded and if you move into a new age bracket, your rates will change in 2019. Please see **optional Life rate table**

OPTIONAL SUPPLEMENTAL LIFE INSURANCE (CONTINUED)

In order to be eligible:

- You must be full-time and actively at work, and not receiving or applying for waiver of premium;
- Have never been declined or refused supplemental life benefits; and
- Your total Supplemental Life benefit does not exceed the lesser of seven (7) times your annual salary or $750,000. Spouse life cannot exceed the employee amount.
- Employees and spouses (spouses under age 60) who have not been previously declined, can either enroll for **new coverage** or **increase current coverage** in the amount of **$10,000** without Evidence of Insurability (EOI) even if over the Guarantee Issue Limit
- Coverage for child life is available only if the employee has at least $10,000 of supplemental life insurance.

Use the Open Enrollment form for changes.

LONG TERM DISABILITY (LTD)

LTD is provided by Reliance Standard Insurance and is available at a minimal cost. Adding LTD will require Evidence of Insurability. Please obtain the EOI form from Human Resources. In order to qualify for this, you must not have been previously declined. LTD is subject to a Pre-Existing Condition Limitation of 6/6/24 that states that a pre-existing condition is any condition for which you...

- 6 Months- received treatment in the 6 months immediately prior to coverage effective date
- 6 Months - received in the 6 months immediately following effective date
- 24 Months – are receiving treatment during the first 24 months of the policy

Use the Open Enrollment form on the portal for changes

FLEXIBLE SPENDING ACCOUNTS (HEALTH/DEPENDENT CARE) - (CURRENT OR NEW PARTICIPANTS MUST ENROLL EVERY YEAR)

Allied Benefit Systems (Account # A09101) is Joliet Junior College's provider for health savings and dependent flexible savings plans. The allowable deduction is now $2,650.00 for the health flexible spending account as of 1/1/19 and $5,000 for the dependent flexible spending account. Enrollment in the FSAs is through the Allied website. See FSA Online Open Enrollment Guide on the portal for instructions on how to sign up on-line for this benefit. You will need your account number. Forgot your account number? You can call Allied at 312-906-8080 or contact Human Resources.

Employees who elect FSA must enroll on-line

HYPERLINK "http://www.alliedbenefit.com"
www.alliedbenefit.com

or by calling
Allied Benefit System at 312-906-8080

Please refer to the FSA Online Enrollment Guide on the JJC Human Resource Portal.

If you need assistance with the on-line enrollment you are also invited to participate on **a webinar given by Allied on Wednesday, November 6, 2019 at 1:00 p.m. Webinar information below**.

https://global.gotomeeting.com/join/434238069

You can also dial in using your phone:

United States: +1 (872) 240-3412

Access Code: 434-238-069