2019

Part-Time Employee Benefits Guide

SOUTHWESTERN™
ILLINOIS COLLEGE

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Benefits That Fit Your Life

At Southwestern Illinois College we value your contributions to our success and want to provide you with a benefits package that protects your health and helps your financial security, now and in the future. We continually look for valuable benefits that support your needs, whether you are single, married, raising a family, or thinking ahead to retirement. We are committed to giving you the resources you need to understand your options and how your choices could affect you financially.

This guide is an overview and does not provide a complete description of all benefit provisions. For more detailed information, please refer to your plan benefit booklets or summary plan descriptions (SPDs). The plan benefit booklets determine how all benefits are paid.

A list of plan contacts is included at the back of this guide.

The benefits in this summary are effective:

January 1, 2019 - December 31, 2019

Who Can You Cover?

WHO IS ELIGIBLE?

Part-time facility and staff working at least 30 or more hours per week are eligible for the benefits outlined in this overview.

You can enroll yourself and the following family members in our Medical Plans, however you will be responsible for 100% of the premium:

- Your Spouse (the person who you are legally married to under state law, including a same-sex spouse.)
- Your Civil Union Partner (and his or her eligible dependents).
- Your Children
    - Natural-born children to age 26.
    - Legally adopted children and children placed with you for legal adoption to age 26.
    - Stepchildren to age 26.
    - Dependent children for whom you or your spouse have been appointed legal guardian to age 26.
    - Children of the employee who are required to be covered by reason of a Qualified Medical Child Support Order (QMCSO), as defined by ERISA § 609a.
    - Unmarried children with disabilities remain eligible after age 26 if they are primarily dependent upon the employee for support. Proof of disability will be requested to continue eligibility.
    - Qualified military personnel until age 30.

Please refer to the Summary Plan Description for complete details on how benefits eligibility is determined.

WHO IS NOT ELIGIBLE?

Family members who are not eligible for coverage include (but are not limited to):

- Parents, grandparents, and siblings.
- Domestic Partners.
- Any individual who is covered as an employee of Southwestern Illinois College cannot also be covered as a dependent.
- Employees who work fewer than 30 hours per week, temporary employees, contract employees, or employees residing outside the United States.

ENROLLMENT PERIODS

Coverage for new employees begins on the date of hire. After that, Open Enrollment is the one time each year that employees can make changes to their benefit elections without a qualifying life event.

Notify Human Resources within 31 days if you have a qualifying life event and need to make changes to your elections, including adding or dropping dependents outside of Open Enrollment. Life events include (but are not limited to):

- Marriage or divorce
- Change in spouse's employment status
- You or a dependent become eligible for Medicare or Medicaid
- Your dependent ceases to satisfy the dependent eligibility requirements
- Gain / Loss of other group coverage

Words You Need to Know

Health insurance seems to have its own language. You will get more out of your plans if you understand the most common terms, explained below in plain English.

MEDICAL

OUT-OF-POCKET COST - A healthcare expense you are responsible for paying with your own money, whether from your bank account, credit card, or from a health account such as an HSA or FSA.

DEDUCTIBLE - The amount of healthcare expenses you have to pay for with your own money before your health plan will pay. The deductible does not apply to preventive care and certain other services.

COINSURANCE - After you meet the deductible amount, you and your health plan share the cost of covered expenses. Coinsurance is always a percentage totaling 100%. For example, if the plan pays 70% coinsurance, you are responsible for paying your coinsurance share, 30% of the cost.

COPAY - A set fee you pay whenever you use a particular healthcare service, for example, when you see your doctor or fill a prescription. After you pay the copay amount, your health plan normally pays the rest of the bill for that service.

IN-NETWORK / OUT-OF-NETWORK - Network providers (doctors, hospitals, labs, etc.) are contracted with your health plan and have agreed to charge lower fees to plan members, as negotiated in their contract with the health plan. Services from out-of-network providers can cost you more because the providers are under no obligation to limit their maximum fees.

OUT-OF-POCKET MAXIMUM - The most you would pay from your own money for covered healthcare expenses in one year. Once you reach your plan's out-of-pocket maximum dollar amount (by paying your deductible, coinsurance and copays), the plan pays for all eligible expenses for the rest of the plan year; however, usual and customary charges may apply when out-of-network providers are utilized.

PRESCRIPTION DRUG

BRAND NAME - A drug sold under its trademarked name. For example, Lipitor is the brand name of a common cholesterol medicine. You generally pay a higher copay for brand name drugs.

GENERIC DRUG - A drug that has the same active ingredients as a brand name drug, but is sold under a different name. For example, Atorvastatin is the generic name for medicines with the same formula as Lipitor. You generally pay a lower copay for generic drugs.

PREFERRED DRUG - Each health plan has a list of prescription medicines that are preferred based on an evaluation of effectiveness and cost. Another name for this list is a "formulary." The plan may charge more for non-preferred drugs or for brand name drugs that have generic versions. Drugs that are not on the preferred drug list may not be covered.

Medical – BlueCross BlueShield of Illinois

Medical coverage provides you with benefits that help keep you healthy, like preventive care screenings and access to urgent care. It also provides important financial protection if you have a serious medical condition.

	HDHP / PPO I Plan		PPO II Plan	
	In-Network	**Out-Of-Network**	**In-Network**	**Out-Of-Network**
Annual Deductible	$3,300 per individual $6,600 family limit	$10,000 per individual $20,000 family limit	$300 per individual $600 family limit	$1,000 per individual $2,000 family limit
Annual Out-of-Pocket Max	$3,300 per individual $6,600 family limit	$13,200 per individual $26,400 family limit	$1,000 per individual $2,000 family limit	$5,000 per individual $10,000 family limit
Lifetime Max	Unlimited	Unlimited	Unlimited	Unlimited
Office Visit				
Primary Provider	Plan pays 100% after deductible	Plan pays 80% after deductible	$25 copay then plan pays 100%	Plan pays 70% after deductible
Specialist	Plan pays 100% after deductible	Plan pays 80% after deductible	$50 copay then plan pays 100%	Plan pays 70% after deductible
Telemedicine	Plan pays 100% after deductible	Not applicable	$25 copay then plan pays 100%	Not applicable
Preventive Services	Plan pays 100%	Plan pays 80% after deductible	Plan pays 100%	Plan pays 70% after deductible
Chiropractic Care (up to 20 visits per year)	Plan pays 100% after deductible	Plan pays 80% after deductible	Plan pays 90% after deductible	Plan pays 70% after deductible
Lab and X-ray	Plan pays 100% after deductible	Plan pays 80% after deductible	Plan pays 90% after deductible	Plan pays 70% after deductible
Inpatient Hospitalization	Plan pays 100% after deductible	Plan pays 80% after deductible	Plan pays 90% after deductible	Plan pays 70% after deductible
Outpatient Surgery	Plan pays 100% after deductible	Plan pays 80% after deductible	Plan pays 90% after deductible	Plan pays 70% after deductible
Urgent Care	Plan pays 100% after deductible	Plan pays 80% after deductible	Plan pays 90% after deductible	Plan pays 70% after deductible
Emergency Room	Plan pays 100% after deductible	Plan pays 100% after deductible	$150 copay then plan pays 100% (copay waived if admitted)	$150 copay then plan pays 100% (copay waived if admitted)

Medical, continued

	PPO III Plan	
	In-Network	**Out-Of-Network**
Annual Deductible	$5,000 per individual $10,000 family limit	$10,000 per individual $20,000 family limit
Annual Out-of-Pocket Max	$6,600 per individual $13,200 family limit	$13,200 per individual $26,400 family limit
Lifetime Max	Unlimited	Unlimited
Office Visit		
Primary Provider	$35 copay then plan pays 100%	Plan pays 60% after deductible
Specialist	$35 copay then plan pays 100%	Plan pays 60% after deductible
Telemedicine	$35 copay then plan pays 100%	Not applicable
Preventive Services	Plan pays 100%	Plan pays 60% after deductible
Chiropractic Care (up to 20 visits per year)	Plan pays 80% after deductible	Plan pays 60% after deductible
Lab and X-ray	Plan pays 80% after deductible	Plan pays 60% after deductible
Inpatient Hospitalization	Plan pays 80% after deductible	Plan pays 60% after deductible
Outpatient Surgery	Plan pays 80% after deductible	Plan pays 60% after deductible
Urgent Care	Plan pays 80% after deductible	Plan pays 60% after deductible
Emergency Room	$150 copay then plan pays 100% (copay waived if admitted)	$150 copay then plan pays 100% (copay waived if admitted)

Prescription Drugs – Prime Therapeutics

Prescription drug coverage provides a benefit that is important to your overall health, whether you need a prescription for a short-term health issue like bronchitis or an ongoing condition like high blood pressure. Here are the prescription drug benefits that are included with our medical plans.

	HDHP / PPO I Plan		PPO II Plan	
	In-Network	**Out-Of-Network**	**In-Network**	**Out-Of-Network**
Prescription Drug Deductible	Prescriptions subject to medical plan deductible	Prescriptions subject to medical plan deductible	Not applicable	Not applicable
Annual Out-of-Pocket Limit	Prescriptions subject to medical out-of-pocket maximums	Prescriptions subject to medical out-of-pocket maximums	$2,500 per individual $5,000 per family	$2,500 per individual (combined with in-network) $5,000 per family (combined with in-network)
Pharmacy				
Generic	Plan pays 100% after deductible	Plan pays 75% after deductible	$10 copay then plan pays 100%	$10 copay then plan pays 75%
Preferred Brand	Plan pays 100% after deductible	Plan pays 75% after deductible	$40 copay then plan pays 100%	$40 copay then plan pays 75%
Non-preferred Brand	Plan pays 100% after deductible	Plan pays 75% after deductible	$60 copay then plan pays 100%	$60 copay then plan pays 75%
Supply Limit	34 days	34 days	34 days	34 days
Mail Order*				
Generic	Plan pays 100% after deductible	Not covered	$20 copay then plan pays 100%	Not covered
Preferred Brand	Plan pays 100% after deductible	Not covered	$80 copay then plan pays 100%	Not covered
Non-preferred Brand	Plan pays 100% after deductible	Not covered	$120 copay then plan pays 100%	Not covered
Supply Limit	90 days	Not applicable	90 days	Not applicable

Prescription Drugs, continued

	PPO III Plan	
	In-Network	**Out-Of-Network**
Prescription Drug Deductible	Not applicable	Not applicable
Annual Out-of-Pocket Limit	Prescriptions subject to medical out-of-pocket maximums	Prescriptions subject to medical out-of-pocket maximums
Pharmacy		
Generic	$15 copay then plan pays 100%	$15 copay then plan pays 75%
Preferred Brand	$30 copay then plan pays 100%	$30 copay then plan pays 75%
Non-preferred Brand	$50 copay then plan pays 100%	$50 copay then plan pays 75%
Supply Limit	34 days	34 days
Mail Order*		
Generic	$30 copay then plan pays 100%	Not covered
Preferred Brand	$60 copay then plan pays 100%	Not covered
Non-preferred Brand	$100 copay then plan pays 100%	Not covered
Supply Limit	90 days	Not applicable

**Alliance Rx Walgreen Prime delivers your long term (maintenance) medicines right where you want them. They deliver up to a 90-day supply to the address of your choice within the United States. You can order online or over the phone. Your doctor can text or send your prescription electronically to Alliance Rx Walgreens Prime.*

Getting Care When You Need It Now

WHEN TO USE THE ER

The emergency room shouldn't be your first choice unless there's a true emergency—a serious or life threatening condition that requires immediate attention or treatment that is only available at a hospital.

WHEN TO USE URGENT CARE

Urgent care is for serious symptoms, pain, or conditions that require immediate medical attention but are not severe or life-threatening and do not require use of a hospital or ER. Urgent care conditions include, but are not limited to: earache, sore throat, rashes, sprains, flu, and fever up to 104°.

WHEN YOU NEED CARE NOW

What do you do when you need care right away, but it’s not an emergency? Call the 24/7 Nurseline to help decide whether you should go to the emergency room or urgent care center or make an appointment with your doctor.

- Call 24/7 Nurseline at 800-299-0274

WHEN TO USE TELEHEALTH POWERED BY MDLIVE

PPO members can video chat with a doctor from the comfort of their own homes, without an appointment. MDLIVE’s telehealth program provides you and your covered dependents access to care for non-emergency medical and behavioral health needs. Whether you’re in a city, a rural area or on a weekend camping trip, you can speak to a doctor immediately to help treat your current condition.

- Call MDLIVE at 888-676-4204
- Visit the website MDLIVE.com/bcbsil

PREVENTIVE OR DIAGNOSTIC?

Preventive care is intended to prevent or detect illness before you notice any symptoms. Diagnostic care treats or diagnoses a problem after you have had symptoms.

Be sure to ask your doctor why a test or service is ordered. Many preventive services are covered at no out-of-pocket cost to you. The same test or service can be preventive, diagnostic, or routine care for a chronic health condition. Depending on why it's done, your share of the cost may change.

Whatever the reason, it's important to keep up with recommended health screenings to avoid more serious and costly health problems down the road.

GOING ABROAD?

When you travel overseas and need protection, take your benefits with you.

BlueCross BlueShield Global Core Program is your passport to healthcare around the globe. The program allows you to have access to medical assistance services, doctors and hospitals in more than 200 countries worldwide.

- Call BlueCross BlueShield Global Core Service Center at 1-800-810-2583 (BLUE) or call collect at 1-804-673-1177
- Visit the website bcbsglobalcore.com

Health Savings Account – Benefit Resource Inc.

Do you want to save money on taxes? A Health Savings Account is a tax-advantaged, portable (you own it!) savings account that is offered if you enroll in the High Deductible Health Plan (HDHP / PPO I). You can contribute pre-tax money to your account to save for out-of-pocket healthcare expenses. Any money that you don't spend grows year after year and can be used in the future, even after you retire.

ANNUAL ACCOUNT CONTRIBUTIONS

	You Can Contribute
Employee	$3,500
Employee + Family	$7,000
Catch Up Contributions	An additional $1,000 per year at age 55+

USING YOUR MONEY

You can use your account to pay for qualified medical expenses that are not paid for by your high deductible health plan (HDHP). In general, your HSA can be used for these expenses:

- Medically necessary expenses that are not covered by your health plan including deductibles and coinsurance
- Dental care services
- Vision care services
- Prescription drugs
- Over-the-counter (OTC) medications prescribed by your doctor
- Certain medical equipment

When possible, use your Beniversal HSA debit card, from Benefit Resource, Inc., to pay for expenses. Make sure that you keep records of your receipts and any OTC prescriptions in case the IRS requests them.

ELIGIBILITY

You are not eligible to open or contribute to an HSA account if you are:

- Covered by a non-high deductible health plan
- Enrolled in a regular healthcare flexible spending account (you or your spouse count)
- Covered under Medicare, Medicaid or Tricare
- Someone else's tax dependent

Non-Qualified Expenses

If you use HSA funds for non-qualified expenses before age 65, you will owe a 20% penalty tax PLUS income tax on the withdrawal. After age 65, if you use HSA funds for non-qualified expenses, you will owe income tax only. Visit irs.gov/publications/p502 for details.

Flexible Spending Account – Benefit Resource Inc.

A Flexible Spending Account lets you set aside money—before it's taxed—through payroll deductions. The money can be used for eligible healthcare and dependent day care expenses you and your family expect to have over the next year. The main benefit of using an FSA is that you reduce your taxable income, which means you have more money to spend. And reimbursements from your FSA accounts are tax-free. The catch is that you have to use the money in your account by our plan year's end. Otherwise, that money is lost, so plan carefully. **You must re-enroll in this program each year.** Benefit Resource, Inc. administers this program.

IMPORTANT CONSIDERATIONS

- There's no "crossover" spending allowed between the healthcare and dependent care accounts.
- Expenses must be incurred between 01/01/19 and 12/31/19 and submitted no later than 04/01/20.
- Elections cannot be changed during the plan year, unless you have a qualified change in family status (and the election change must be consistent with the event).
- Unused amounts will be lost at the end of the plan year, so it is very important that you plan carefully before making your election.
- FSA funds can be used for eligible expenses incurred by you, your spouse, and your tax dependents only. Your spouse or tax dependent children do not have to be enrolled in a Southwestern Illinois College health plan.
- You cannot obtain reimbursement for eligible expenses for a domestic partner or their children, unless they qualify as your tax dependents (Important: questions about the tax status of your dependents should be addressed with your tax advisor).
- Keep your receipts as proof that your expenses were eligible for IRS purposes.
- Benefit Resource issues a Beneversal Prepaid MasterCard. This allows you to use the FSA funds to pay for eligible expenses at qualified merchants accepting Debit MasterCard.

TAX-FREE HEALTHCARE FSA

Eligible expenses include medical, prescription dental, and vision costs including plan deductibles, copays, coinsurance amounts, and other non-covered healthcare costs for you and your tax dependents. You may access your entire annual election from the first day of the plan year and you can set aside up to $2,650 per year. If you are enrolled in the HDHP / PPO I Plan, you can participate in our **Limited Purpose Healthcare FSA** which covers out-of-pocket vision and dental expenses ONLY.

TAX-FREE DEPENDENT CARE FSA

Eligible expenses may include daycare centers, in-home child care, and before or after school care for your dependent children under age 13. Other individuals may qualify if they are your tax dependent and are incapable of self-care. It is important to note that you can access money only after it is placed into your dependent care FSA account.

All caregivers must have a tax ID or Social Security number. This information must be included on your federal tax return. If you use the dependent care reimbursement account, the IRS will not allow you to claim a dependent care credit for reimbursed expenses. Consult your tax advisor to determine whether you should enroll in this plan. You can set aside up to $5,000 per household for eligible dependent care expenses for the year.

403(b) Retirement Savings Account - OMNI

403(b) RETIREMENT SAVINGS ACCOUNT

The College makes available to you a retirement savings plan to assist you in planning for your retirement. It is possible for you to supplement your SURS retirement program with a pre-tax investment program. This program is called a section 403(b) retirement savings account. It offers you an excellent opportunity to set money aside for the future without paying taxes right away. There are a number of complex rules pertaining to the tax treatment of 403(b) accounts. Faculty and staff members who choose to participate in the 403(b) program are advised to seek their own tax accounting advice. For 2018, the maximum annual contribution is limited to $18,500 (subject to change by the IRS for 2019). Employees age 50 and above are entitled to make additional contributions of $6,000 per year under the “catch up” provisions.

To participate, you must open an account with an approved investment provider. Then complete the enrollment/change form found on the Benefits Infoshare page.

For additional information regarding the 403(b) retirement savings plan, please review the informational flyer on the Benefits Infoshare page.

U.S. OMNI administers the plan and is available to answer questions at (877) 544-6664 or visit www.omni403b.com.

Cost of Coverage

HDHP PPO I Plan	Your Cost Per Month
Employee Only	$715.12
Family	$2,216.89
PPO II Plan	**Your Cost Per Month**
Employee Only	$801.60
Family	$2,484.94
PPO III Plan	**Your Cost Per Month**
Employee Only	$99.00
Family	$1,483.48

Costs are monthly and rounded to the nearest cent.

For Assistance

YOUR BENEFIT ADVOCATE - COMPASS PROFESSIONAL HEALTH SERVICES

Southwestern Illinois College offers you confidential access to Benefit Health Pros. Health benefits can be confusing, medical costs are rising, and finding the right care for you and your family can be frustrating and time consuming. Compass is here to simplify your healthcare experience and help you take control of healthcare costs. Your personal Compass Health Pro consultant will take care of you, so you can take care of other things. Compass can help you…

- Understand insurance benefits
- Find highly rated doctors
- Save money on healthcare
- Pay less for prescriptions
- Resolve billings errors
- Schedule your appointments

Contact Compass between 8:00 AM & 6:00 PM CST at 1-800-513-1667 or email answers@compassphs.com.

Benefit Provider Customer Service List

If you need to reach our plan providers, here is their contact information:

Provider	Plan Type	Phone Number	Website
BlueCross BlueShield of Illinois	Medical	1-800-828-3116	www.bcbsil.com
BRi Benefit Resource, Inc.	HSA & FSA	1-800-473-9595	www.benefitresource.com
PRIME THERAPEUTICS	Prescription Drug	1-800-423-1973	www.primetherapeutics.com
allianceRx Walgreens + PRIME	Mail Order	1-877-357-7463	https://www.alliancerxwp.com/home-delivery
COMPASS Healthcare Redefined.	Benefit Health Pro	1-800-513-1667	www.compassphs.com

Important Plan Notices and Documents

CURRENT HEALTH PLAN NOTICES

Notices must be provided to plan participants on an annual basis and are available on the HR – Benefits Infoshare page and include:

- Medicare Part D Notice
  Describes options to access prescription drug coverage for Medicare eligible individuals.
- Women's Health and Cancer Rights Act
  Describes benefits available to those that will or have undergone a mastectomy.
- Newborns' and Mothers' Health Protection Act
  Describes the rights of mother and newborn to stay in the hospital 48-96 hours after delivery.
- HIPAA Notice of Special Enrollment Rights
  Describes when you can enroll yourself and/or dependents in health coverage outside of open enrollment.
- HIPAA Notice of Privacy Practices
  Describes how health information about you may be used and disclosed.
- Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)
  Describes availability of premium assistance for Medicaid eligible dependents.

COBRA CONTINUATION COVERAGE

You and/or your dependents may have the right to continue coverage after you lose eligibility under the terms of our health plan. Upon enrollment, you and your dependents receive a COBRA Initial Notice that outlines the circumstances under which continued coverage is available and your obligations to notify the plan when you or your dependents experience a qualifying event. Please review this Notice carefully to make sure you understand your rights and obligations.

Summary Plan Descriptions

A Summary Plan Description (SPD) is the legal document for describing benefits provided under the plan as well as plan rights and obligations to participants and beneficiaries. The following Summary Plan descriptions are available on the HR – Benefits Infoshare page:

- HDHP / PPO I Plan
- PPO II Plan
- PPO III Plan

Summary of Benefits and Coverage

A Summary of Benefits and Coverage (SBC) is a document required by the Affordable Care Act (ACA) that presents benefit plan features in a standardized format. The following SBCs are available on the HR – Benefits Infoshare page:

- HDHP / PPO I Plan
- PPO II Plan
- PPO III Plan

Paper copies of these documents and notices are available if requested. If you would like a paper copy, please contact Human Resources at (618) 222-5254.

Notes

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