Lake Land College
2018 Benefit Booklet

LAKE LAND
COLLEGE

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Refer to this list when you need to contact one of your benefits vendors.
For general information, contact Human Resources.

BENEFIT CONTACTS	
Medical and Prescription Drugs	Aetna Phone: 1-800-872-3862 www.aetna.com
Health Savings Account	PayFlex Phone: 1-844-729-3539 www.payflex.com
Voluntary Dental	Aetna Phone: 1-800-872-3862 www.aetna.com
Voluntary Vision	Aetna Phone: 1-800-872-3862 www.aetna.com
Life Insurance	Aetna Phone: 1-800-872-3862 www.aetna.com
Optional Life	Aetna Phone: 1-800-872-3862 www.aetna.com
Flexible Spending Account	BPC www.bpcinc.com Phone: 877-272-8880
Disability / Supplemental Insurances	AFLAC www.aflac.com 217-932-2109
403b/457b	Wells Fargo 888-527-2212
Employee Assistance Program 10 free visits per year	Sarah Bush Lincoln Health Center 217-258-4040
SURS	SURS www.surs.org 800-275-7877

Human Resource Contact Information

Contact	Email	Phone
Human Resources	humanresources@lakelandcollege.edu	217-234-5000

BENEFIT GUIDE INTRODUCTION

Benefits are an important part of your total compensation package. That's why Lake Land College is committed to providing eligible employees with a variety of solutions to address their benefit needs, as well as the needs of their family.

You have the flexibility to choose the benefits that best fit your needs. Many of these benefits are paid for - in whole or in part – by Lake Land College. Other benefits are offered as voluntary options you can choose to pay for through the convenience of payroll deductions.

This handbook provides a summary of benefit programs available to you and provides you with information to make informed decisions for you and your family. Your choices will be in effect for the entire 2018 calendar year. Please review these materials carefully and keep them as a handy reference guide for your 2018 benefits. For more detailed information on each of the plans, please see the plan summaries/documents available from your human resources office.

Plan documents take precedence over this or any other summary benefit documents. Employee benefits are subject to modification or termination at any time. This information is provided by Lake Land College Human Resources and is intended as general information for Lake Land College Employees and Plan Participants. Every effort has been made to ensure that the information contained in this Benefits Handbook is accurate and reliable. If there is a discrepancy between this Benefits Guide and the Summary Plan Description or Carrier Benefit Summary, the actual plan documents from the insurance company will prevail. Lake Land College Human Resources Office does not provide legal or tax advice and nothing herein should be construed as legal or tax advice. If you would like additional information concerning the benefit plans you may contact the Human Resources department.

ELIGIBILITY / EFFECTIVE DATES / ENROLLMENT

Full-time employees and their eligible dependents are able to participate in Lake Land College benefit plans.

Eligible dependents for benefit plans include:

- Legal Spouse
- Civil Union Partner
- Eligible Dependent Children under age 26
- Adult Dependents incapable of self-support because of a mental or physical handicap and who became incapable of self-support before age 26 while covered as a dependent under this or any other group plan

WHEN AM I ELIGIBLE?

Benefit plan eligibility varies by benefit plan. Medical, Dental, Vision and Life insurance is effective on the date of hire. Your coverage end date will be the last day of the month in which you cease to be an active employee. Your dependents are covered through the end of the month in which they cease to be an eligible dependent. Life insurance ends on your date of termination.

HOW DO I ENROLL OR MAKE CHANGES?

Newly hired or newly eligible employees can enroll in any of the benefit plans within 30 days of their initial eligibility date. Benefit enrollment forms must be completed and returned to Human Resources within 30 days of your date of hire or date of eligibility.

Changes to existing benefit participation can only be made during the annual open enrollment period unless there is a qualifying life event, such as marriage/civil union, divorce, birth/adoption, death or loss/gain of other

coverage, loss of dependent status, or change in employment status. Human Resources must be notified and any enrollment changes must be made within 30 days of the life event.

ENROLLMENT INSTRUCTIONS

Open enrollment is held annually between November 1-November 30. Once your elections are made, your benefit elections will remain in effect for the entire plan year. Only a qualified status change allows you to make changes to your benefit elections within 31 days after any of the following events:

- Marriage, divorce, or legal separation
- Birth or adoption of a child
- Death of a spouse or child
- Loss of benefits for you or your covered dependents because of a change in employment
- A significant increase or decrease in the cost of a benefit in accordance with the rules under Internal Revenue Code Section 125, as long as the election change is consistent with the event and the change is requested within 60 days of the event

BENEFIT PLANS OFFERED

- Medical
- Dental
- Vision
- Life
- Aflac supplemental coverages
- 403(b) / 457(b) Plans
- Employee Assistance Program
- Flexible Spending Account
- Health Savings Account

2018 PLAN CHANGES

- Increase in Plan A and Plan B employee level deductible and out of pocket maximum of $250
- Increase in Plan A and Plan B employee +1 and family deductible and out of pocket maximum of $500
- Increase in Physician office visit to $25 on Plan A
- Increase in Specialist office visit to $35 on Plan A
- Increase in medical premium of approximately 4.15% for employee +1 and family levels
- No premium or product design changes to dental, vision or life

MEDICAL BENEFITS

We are pleased to offer two Aetna PPO medical plan options. With the PPO, you may select where you have medical services. If you use in-network providers, your cost will be less. The name of the network is Aetna Choice POS II.

PLAN A (TRADITIONAL PLAN)

The Traditional Plan is a PPO plan with an annual in-network deductible of $1000 (individual) and $2000 (family), 10% co-insurance for most in-network services, $25 co-pay for physician office visits and $35 co-pay for specialist office visits. This plan provides preventive wellness benefits for routine physical exams, immunizations, well baby care, and routine screenings and tests. Preventive wellness services are covered at 100%. Prescription drugs are available with a co-pay depending on the brand status of the prescription. Mail order is available at a greater discount. Prescriptions do not count towards deductible, but they are applied towards the plan's out-of-pocket maximum. The out of pocket maximum in-network is $2,500 (individual) and $5,000 (family).

PLAN B (HIGH DEDUCTIBLE HEALTH PLAN)

The High Deductible Health Plan (HDHP) combines a PPO plan with a tax-free Health Savings Account (HSA) to help cover health care expenses paid out of pocket, such as deductible and co-insurance. This plan has an annual in-network deductible of $2,250 (individual) and $4,500 (family). Once the deductible is met you have a 10% co-insurance for most in-network services, including physician office visits. The entire deductible must be satisfied before any health plan benefits begin. Preventive wellness benefits are covered at 100% with no deductible or co-insurance. In-network Prescription coverage begins once the entire deductible has been met. Prescription coverage has a 10% co-pay for all drug categories. Prescription costs are applied towards the plan's deductible and out-of-pocket maximums. The out of pocket maximum in-network is $4,250 (individual) and $7,050 (family).

FINDING NETWORK PROVIDERS

Aetna Provider Finder – Go to ***www.aetna.com*** or call the number on the back of your Aetna card.

WAYS TO MAXIMIZE YOUR BENEFITS

- Make sure you doctor, hospital or dentist in in-network
- Find a provider in Aetna's Navigator Network-www.aetna.com
- Remember that certain medical preventative care is covered at 100%
- Ask your doctor for a lower cost alternative prescription
- Use Emergency Room ONLY for emergencies

The medical option you select applies for all of 2018. You will not be able to change your medical coverage during the plan year unless you incur a qualifying life event.

MEDICAL SCHEDULE OF BENEFITS

The schedule of benefits provides a brief overview of the health benefits and features of each of the plans in-network options. These are only summaries, not the actual plan descriptions. Certificates of coverage fully describe the terms of coverage and are available from Human Resources.

In-Network Coverage (Employee Responsibility)		
	Aetna Plan A (Traditional)	**Aetna Plan B (HDHP)**
Individual In Network Medical Deductible	$1,000	$2,250* **(entire deductible must be met)**
Family Medical In Network Deductible	$2,000	$4,500 **(entire deductible must be met)**
Plan Year Out-of-Pocket Maximums (In Network, Includes deductible)	$2,500 Individual $5,000 Family	$4,250 Individual $7,050 Family
Lifetime Maximum Benefits	Unlimited unless otherwise indicated	Unlimited unless otherwise indicated
Inpatient In Network Hospital Services	10% after deductible	10% after deductible
Outpatient In Network Emergency Room	10% after deductible	10% after deductible
In Network Preventative Wellness Services	100%	100%
In Network Physician Office Visit	$25 Copay; deductible waived	10% after deductible
In Network Specialist Office Visit	$35 Copay; deductible waived	10% after deductible
Durable Medical Equipment	10% after deductible	10% after deductible
Rehabilitation & Muscle Manipulation	$25 Copay; after deductible *(20 visits/year limit)*	10% after deductible *(20 visits/year limit)*
Prescription Drugs	Time of Purchase: Generic $10 Preferred $25 Non-Preferred Brand $40 Premier Plus Specialty $70 **Rx costs do NOT go towards deductible, but do go towards out-of pocket-max*	**Must meet entire medical deductible then:** Generic 10% Formulary 10% Non-Preferred Brand 10% Premier Plus Specialty 10% **Rx costs go towards deductible and out-of-pocket max*
HSA account Eligible	No	Yes

*****On the HDHP plan, the $2,250 deductible only applies if you have individual only coverage. If you have any other coverage level, the $4,500 deductible applies and $4,500 must be met before anything is covered for any family member on the plan.

**A complete schedule of benefits can be found on; S:\Human Resources\Benefits

MAIL ORDER PRESCRIPTION

AETNA MAIL ORDER PRESCRIPTION SERVICE

Get started now — follow these steps:

Step 1-

Ask your doctor to write TWO prescriptions.
Prescription #1: Is for a one-month supply. Fill it at a local retail pharmacy. With this short-term supply you will have enough of your medicine on hand to see you through until your first Aetna Rx Home Delivery order arrives.

Prescription #2: Is typically for a 90-day supply (with three refills). Send this one to Aetna Rx Home Delivery.

Step 2-

Choose one of these ways to submit your order:

1. Mail
Mail us your prescription for a 90-day supply along with a completed order form. You can access it online. Visit **www.aetna.com** and log in to your secure member website. Or go directly to **www.aetnanavigator.com**.

2. Fax
Ask your doctor to fax in your new prescription, with your completed order form. The fax number is **1-877-270-3317**. Make sure your doctor includes your Aetna member ID number, your date of birth and your mailing address on the fax cover sheet. Only a doctor may fax a prescription.

3. Phone

Call us toll-free: **1-888-RX AETNA (1-888-792-3862)** or **TDD: 1-800-823-6373**. With our Aetna Rx Courtesy Start℠ program, we can contact your doctor on your behalf to attempt to get a new prescription for you.

Ordering refills is easy — choose one of these ways:

1. Online
You can go online to order refills, track the status of an order and more. Just visit **www.aetna.com** and your secure member website. Or go directly to **www.aetnanavigator.com**.

2. By phone
Call Rx Member Services toll-free at **1-888-RX AETNA (1-888-792-3862)**. Have your member ID number, your prescription number and your credit card number ready.

3. By mail
Send in the reorder form that you received with your last order. Mail it back with your payment. The reorder form will also tell you when you can place your next refill order

PREVENTION

PREVENTION REALLY IS THE BEST MEDICINE

Preventive care counts
You don't need to feel sick to see your doctor. In fact, the best time to go is *before* you have a health issue. Maybe you need a flu shot. A health screening. Or perhaps you'd just like some tips to live healthy. That's preventive care.

No extra costs
Most health plans fully cover preventive care. So you and your family may get these important services at no cost.

That's right. No copays, deductibles or coinsurance (a percent of the total cost). Just check your plan details.

More healthy services
Preventive care starts with a checkup. It can also include:
• Flu, pneumonia and other shots
• Blood pressure, diabetes and cholesterol tests
• Counseling, screening and vaccines for healthy pregnancies
• Cancer screenings, including colonoscopies and mammograms
Preventive care isn't limited to shots and screenings. One-on-one discussions with your doctor count, too. Like exploring ways to stop smoking, eat healthy or exercise.

Preventive versus diagnostic care
Let's say your doctor wants you to have a colonoscopy because of your age or family history. That's *preventive care*. Remember, this usually costs nothing extra. On the other hand, your doctor might suggest a colonoscopy because you're having symptoms. That's *diagnostic care*. You may have to pay part of the costs.

A yearly checkup for years of rewards
Regular physicals are a key part of preventive care. They can reassure you that you're as healthy as you feel. Or prompt you to ask about changes in your body that might not be normal.

What to expect
Your doctor will measure your height, weight, blood sugar, cholesterol and blood pressure. These results, along with your health history, give your doctor a clearer picture of your health. So he or she can build a personal care plan for you.
A checkup can also:
• Get you up to date with the right screenings for your age
• Spot signs and symptoms that could lead to serious illness
• Help with early diagnosis and treatment
Plus — it can help you build a better relationship with your doctor, for better health.

For a more comprehensive list of preventive care procedures, please go to; S:\Human Resources\Benefits

DENTAL BENEFITS

Employees may elect a voluntary dental plan provided by Aetna. This is a passive PPO with PPO II Network. This means you may elect dentists out of the network for a slight increase in charges.

FINDING NETWORK PROVIDERS

Find participating dentists at ***www.aetna.com***.

Dental Benefits	In-Network Coverage
Annual Deductible (applies to basic and major services)	$50 Single, $100 Family
Annual Maximum Benefit (not including orthodontic services)	$2,000/person
Diagnostic & Preventative Care • Oral exams, cleanings, bitewing x-rays • Fluoride treatment for dependents under 19 (once per year)	Plan pays 100% (no deductible)
Basic Services • Root canal therapy • Amalgam and Composite Fillings • Simple extractions • Space maintainers • Stainless steel crowns • Crowns • Denture repair	Plan pays 80% of the negotiated reduced fee or maximum allowable fee, after deductible
Major Services • Inlays • Onlays • Full and partial dentures • Pontics • Crown build-ups	Plan pays 50% of the negotiated reduced fee or maximum allowable fee, after deductible
Orthodontia • Available only for dependent children under the age of 20 • Must be enrolled in Employee/Children or Family coverage	Plan pays 50% of the negotiated reduced fee or maximum allowable fee Deductible DOES NOT apply $1,500 lifetime Ortho maximum per eligible dependent

*A complete schedule of benefits can be found at; S:\Human Resources\Benefits

VISION BENEFITS

Employees may elect a voluntary vision care program provided through Aetna. The vision plan is designed to protect your visual wellness by offering eye exams, lenses and frames through Aetna's network of private physicians for a small co-payment. Out-of-network coverage is also available, but at a much higher out-of-pocket expense.

AETNA PLAN OPTION

The vision plan allows participants to get new frames every other year and new lenses each year or contact lenses each year. The plan also provides discounts on lens options such as scratch resistant coating, anti-reflective coatings, progressive lenses, prescription sunglasses, and laser vision correction. Injury or damage to healthy eyes is not covered under the Vision Plan but may be covered under your medical plan.

FINDING NETWORK PROVIDERS

Contact Aetna at ***http://aetna.com*** or call to find participating providers, then call your provider to make an appointment.

Vision Benefits	In-Network Co-pay/Allowance	Frequency
Well Vision Exam	$10 co-pay	Every 12 months
Lenses • Single vision, lined bifocal, and lined trifocal lenses • Polycarbonate lenses for dependent children	$10 co-pay	Every 12 months
Lens Enhancements • Standard progressive lenses • Premium progressive lenses • Custom progressive lenses • Other lens enhancements	$75 See plan See plan See plan	Every 12 months
Frames	$130 allowance, plus 20% discount on the amount over your allowance	Every 24 months
Contact Lens (instead of glasses)	$115 allowance 15% discount off contact lens exam	Every 12 months
Additional Discounts • Additional pairs of eyeglasses • Non covered items such as cleaning cloths and lens solution	40% discount 20% discount	As needed
Laser Vision Correction	Avg. 15% off regular price or 5% off promotional price, discounts available only from contracted facilities	

FLEXIBLE SPENDING ACCOUNTS

Flexible spending accounts are administered through Benefit Planning Consultants (BPC). Flexible Spending Accounts allow you to set aside pre-tax dollars to pay for certain medical and dependent care expenses through payroll deductions. By paying these expenses before being taxed, you may lower your taxable income, pay less in taxes, and increase your take-home pay. If you elect to participate, your contributions will be deducted equally from each paycheck (24 per year) throughout the year.

You can access your Health and Dependent care FSA at any time by registering via the BPC Portal. You will be able to submit claims online, check your balance, and view the list of FAQ's. Once you are enrolled you may visit www.bpcinc.com and click "Access Your Participant Account."

There are two Flexible Spending Accounts (FSA) available to employees – unreimbursed medical expenses and dependent care. Each account has contribution limits and certain qualifying expenses. The money in these accounts is used to pay for expenses incurred by an employee, his/her spouse and his/her qualified dependent children.

2018 FSA Contribution Limits	Maximum
Unreimbursed Medical Expenses	$2,650
Dependent Care	$5,000
Dependent Care (married filing separately)	$2,500

*Combined spousal contributions cannot exceed plan maximum contribution limits

UNREIMBURSED MEDICAL EXPENSES FSA

The unreimbursed medical expenses FSA can be used to receive reimbursement for the following types of expenses incurred by you and/or your tax-qualified eligible dependents (*dependents must be under the age of 19 at the end of 2018, under the age of 24 if a full-time student at the end of 2018, or permanently or totally disabled and must have lived with you for more than half of 2017 and did not provide half of his/her own support in 2017)*:

- Medical, prescription, dental or vision expenses not covered or reimbursed by any other health plan
- Deductibles, co-pays and co-insurance
- Amounts over usual and customary charges
- Amounts exceeding Plan maximums
- Certain over-the-counter medical supplies including bandages, diabetes testing supplies, splints, supports and braces, canes and walkers, insulin, hearing aid batteries, contact lenses and solution, nebulizers, etc.

The total elected amount of the Unreimbursed Medical Expenses FSA is available for family expenses on January 1st of the election year. This allows the money to be available to cover deductibles and any unforeseen up-front costs.

DEPENDENT CARE FSA

The dependent care FSA can be used to receive reimbursement for the following types of day care expenses for eligible dependents *(which include child dependents and adult dependents that are living in your household that you must provide daycare for so that you and your spouse may work).*

- Licensed day care center, nursery school, pre-school and kindergarten charges, if the center or school complies with state and federal regulations
- Babysitter cost or wages, or salary for a care provider inside or outside your home. If the care provider is a relative, he or she must be age 19 or older, and cannot be your dependent
- Custodial care in your home or at a facility for your elderly or disabled dependent who is unable to care for himself or herself

Your Dependent Care FSA will only have the balance of your actual payroll deduction available. Unlike the unreimbursed medical expenses FSA, the contribution from your pay has to actually be in the account before you can be reimbursed for a claim. Claims can be made against your account; however, distribution payments will not be made until the account can cover the amount of the claim.

THINGS TO KNOW ABOUT FSAs

- **File FSA Claims on Time:** FSA reimbursement can only be made for expenses incurred during the plan year in which contributions are made to the FSA. Expenses are considered "incurred" on the date the service is performed, not the date the bill is received or paid.
- **Use It or Lose It:** Federal regulations require that if at the end of the year you do not spend the money in your account for eligible expenses, you must forfeit the remaining balance after the deadline to submit claims. The money left in one account cannot be used to cover expenses in the other. *Each plan can have its own run-out period that would allow for additional time after the end of the year to submit any claims.*
- **New Rollover Option:** The IRS Notice 2013-71 permits Section 125 plans to allow $25 to $500 of unused amounts remaining at the end of a plan year in a health FSA to be paid or reimbursed to plan participants for qualified medical expenses incurred during the following year.
- **Important Tax Notices:** You should keep copies of any FSA documentation (receipts/billing) with a copy of the claim and keep this information in a tax file. If an employee's personal tax return is being audited, the employee will be liable to prove the expenses claimed against the account. Under current tax law, you can be reimbursed for eligible dependent care expenses through the dependent care FSA, or you can claim a tax credit for dependent care expenses when you file your federal income tax return. You may be able to use both approaches, but you cannot take a deduction for the same expense twice.

HEALTH SAVINGS ACCOUNTS

Lake Land College makes a bi-monthly contribution to help fund your H.S.A. Participants in the HDHP are also eligible to contribute pre-tax contributions to a Health Savings Account (HSA) up to the I.R.S. Section 223, contribution limits. The funds contributed can be used for qualifying medical expenses. Funds are only available for use as they are contributed and any unused funds rollover to the next year. Proper coordination of contributions and distributions from these accounts is very important and is the responsibility of the participant.

The Health Savings Account is administered by PayFlex. An H.S.A. is a tax-free account you can use to pay for current and future medical expenses (even medical expenses during retirement). An H.S.A. has triple tax benefits;

- Money is contributed to the account tax-free
- Money grows tax-free
- Withdraws for qualified medical, dental, and vision expenses are tax-free

To be eligible to contribute to an H.S.A.;

- You must be covered under a qualified high deductible health plan
- You may not be covered by any other health plan (such as a spouse's plan) that is not a qualified High Deductible Health Plan
- You are not entitled to Medicare benefits, TRICARE or TRICARE for life, and/or you have not received VA health benefits within the past 3 months for a non-service related issues (exceptions do apply)
- You are not eligible to be claimed as a dependent on someone else's tax return
- You are not covered by a health care flexible spending account for the tax year in which you will claim your H.S.A. deposits as tax deductions.

How much can you contribute in 2018?

- Up to $3,450 if enrolled in single coverage
- Up to $6,900 if enrolled in family coverage
- $1,000 additional if you are 55 or older

- Limits include the College contribution

AGE 65 PARTICPANTS

Upon reaching age 65 and enrolling in Medicare, participants will no longer be eligible to contribute to their HSA. Their HSA funds continue to be available for qualified medical expenses. If the HSA funds are used for non-qualified expenses, the distribution will be subject to applicable federal and state taxes but is exempt from the penalty tax. HSA funds can be used to pay for certain insurance premiums such as, Medicare Parts A and B, Medicare HMO, or a share of retiree medical coverage offered by a former employer. Funds cannot be used tax-free to purchase Medigap or Medicare supplemental policies.

COORDINATION OF HSA AND FSA USE

Participants in the High Deductible Health Plan can utilize both a Health Saving Account (HSA) and a Flexible Spending Account (FSA) for qualifying expenses. If a participant decides to take advantage of both types of accounts, the coordination of the use of the funds is regulated by the IRS and can be used by one of the two following approved methods:

- **Limited purpose FSA** – A participant can utilize the HSA for all qualifying medical expenses and utilize the FSA for all qualifying dental and vision expenses.
- **Post-Deductible FSA** – A participant can utilize the HSA for the first $1,300 of qualifying medical expenses (if the participant has employee only coverage) or the first $2,600 of qualifying medical expenses (if the participant has any other coverage level). Then the FSA can be used for any remaining qualifying medical expenses and any qualifying dental and vision expenses. Once the FSA funds are exhausted, the HSA can be used for all remaining qualifying expenses.

The risk and tax liability associated with HSA and FSA coordination is assumed by the participant. HSA and FSA eligible expenses are determined by the IRS and are frequently updated. Please contact your tax advisor for more information on the tax implications for combining the HSA and FSA during a tax year.

HSA account holders will be required to report HSA contributions (employee and employer) and distributions with their annual filing through IRS Form 8889.

LIFE INSURANCE

BASIC LIFE AND AD&D INSURANCE

Basic life insurance is offered through Aetna. Lake Land College provides you with the following life Insurance benefit;

You qualify if you are an active full-time employee, as defined by board policy. Lake Land College provides a set amount of coverage based on your job class. If your death is the result of an accident, your beneficiary will receive double the amount of your Basic Life Insurance.

OPTIONAL LIFE AND AD&D INSURANCE

Optional Life and AD&D is offered through Aetna. You can buy coverage called Optional Life Insurance for yourself, your spouse, and your children. You can purchase this optional coverage in the following increments;

- Employee-5x your basic annual earnings up to a max of $750k
- Your Spouse-Increments of $5k up to a max of $375k
- Your Children-Increments of $2,500 up to a max of $10k

Guarantee Issue Amounts:

- Employee-$150k
- Your Spouse-$100k
- Your Children-$10k

During our annual open enrollment, you have the opportunity to increase your Optional Life an additional $10,000 without having to answer any health questions or providing evidence of good health up to the $150,000 guarantee issue amount. To obtain more than $150,000, you will be required to answer a health questionnaire.

Employees who previously declined the Optional Life benefit and would now like to enroll, must complete the evidence of insurability questionnaire.

Beneficiaries-If a minor child is named as your beneficiary, life insurance benefits will not be paid until the child reaches age of majority.

Contact Human Resources if you are interested in enrolling in optional life or making changes to your current life benefits.

403(B) / 457(B) SAVINGS PLAN

Employees have the opportunity to elect to participate in a tax-deferred savings plan. A tax-deferred saving plan is a voluntary program to help employees provide for retirement. You save by placing pre-tax dollars into an account, thereby reducing current taxable income. Investment earnings accumulate and compound on a tax-deferred basis until retirement. Please note that income is tax deferred, not tax exempt. Your 403 (b)(7) and 457 Savings plans contributions and any rollover contributions you have made are always 100% vested. These Plans offers a wide range of investment options so you can put your money to work in a number of ways. Participants can make changes to their contribution rates, investment options, and account allocation at any time.

If you are interested in starting at 403b or 457b plan or making changes to your current elections, please contact Human Resources or Wells Fargo at 217.345.9500.

How do the plans differ?

403(b)	457(b)
Less stringent withdrawal restrictions while you are employed, but a 10% federal early withdrawal penalty might apply.	More stringent withdrawal restrictions while you are employed, but no 10% federal early withdrawal penalty after severance from employment (except in the case of rollovers from non-457(b) plans, including IRAs).
Generally withdrawals made prior to severance from employment or the year you attain age 59 ½ can only be made due to financial hardship.	Generally withdrawals made prior to severance from employment or the year in which you reach age 70 ½ can only be made for an unforeseeable emergency.
A financial hardship withdrawal is considered less restrictive – while you are employed – than a 457(b) unforeseeable emergency. Example of financial hardship include: • Unreimbursed medical expenses • Payments to purchase a principal residence • Higher education expenses • Payments to prevent eviction or foreclosure of a mortgage	An unforeseeable emergency is more restrictive – while you are employed – than 403(b) hardship. Some examples are: • A sudden and unexpected illness or accident for you or a dependent • Loss of your property due to casualty • Other similar extraordinary circumstances arising as a result of events beyond your control. Sending a child to college or purchasing a home, two common reasons for 403(b) hardship withdrawals, generally are not considered unforeseeable emergencies.
Withdrawals can be subject to a 10% federal early withdrawal penalty prior to age 59 ½.	The 10% federal early withdrawal penalty, generally applicable to distributions prior to age 59 ½ from a 403(b) plan, does not apply to distributions from 457(b) plans except on amounts rolled into the plan from non-457(b) plans (including RSAs).

Aflac for Lake Land College Employees

The following Aflac policies are available;

1

- Emergency Treatment Benefit
- Specific-Sum Injuries
- Accidental-Death
- Initial Hospital Confinement
- Hospital Confinement

2

- Initial Diagnosis Benefit
- Radiation and Chemotherapy
- Surgical/Anesthesia Benefit
- Ambulance, Transportation and Lodging Benefits
- Cancer Wellness Benefit

3

- Short Term Disability
- Other Supplemental Insurances
- Expedited claims processing

For more information about policy benefits, limitations, and exclusions, please call your Aflac representative or contact Human Resources at 217-234-5000. www.aflac.com

Aflac®

We've got you under our wing.®

2018 LAKE LAND COLLEGE INSURANCE RATES

PLAN A, TRADITIONAL	Total Monthly Premium	Employer Share	Employee Share Per Month	Employee Share Per Pay Period
Single	1028.63	1028.63	0.00	0.00
Single + 1	2113.61	1571.12	542.49	271.25
Family	2466.25	1747.44	718.81	359.41

PLAN B, HDHP	Total Monthly Premium	Employer Share	Employee Share Per Month	Employee Share Per Pay Period
Single	794.40	794.40	0.00	0.00
Single + 1	1618.04	1323.34	294.71	147.35
Family	1938.38	1483.51	454.88	227.44

HEALTH SAVINGS ACCOUNT	Total Annual	Total Per Month	Amount Per Pay Period
Single	2810.76	234.23	117.12
Single + 1	2973.42	247.79	123.89
Family	3167.22	263.94	131.97

DENTAL	Total Monthly Premium	Employer Share	Employee Share Per Month	Employee Share Per Pay Period
Single	34.99	34.99	0.00	0.00
Single + 1	63.03	49.01	14.02	7.01
Family	79.33	57.16	22.17	11.09

VISION	Total Monthly Premium	Employee Share Per Month	Employee Share Per Pay Period
Single	5.14	5.14	2.57
Single + 1	10.38	10.38	5.19
Family	17.35	17.35	8.68

2018 LIFE INSURANCE RATES

LAKE LAND COLLEGE

Optional Life and AD&D Quick Reference Chart

The employee can elect optional benefits on themselves and/or their spouse. Benefits are elected in increments of $10,000 up to a maximum of $750,000. Benefits cannot exceed 5x annual salary or $750,000, whichever is less. Spouse coverage cannot exceed the employee's optional benefit.

Guarantee Issue Amounts if elected within 31 days of hire:

Employee: $150,000

Spouse: $100,000

Monthly Cost for Age of Employee and Spouse

Amount of Coverage	Under Age 30	30 through 39	40 through 44	45 through 49	50 through 54	55 through 59	60 through 64	64 through 69	70 +
$10,000	$0.60	$0.77	$1.20	$1.80	$2.83	$4.62	$7.35	$11.55	$23.40
$20,000	$1.20	$1.54	$2.40	$3.60	$5.66	$9.24	$14.70	$23.10	$46.80
$30,000	$1.80	$2.31	$3.60	$5.40	$8.49	$13.86	$22.05	$34.65	$70.20
$40,000	$2.40	$3.08	$4.80	$7.20	$11.32	$18.48	$29.40	$46.20	$93.60
$50,000	$3.00	$3.85	$6.00	$9.00	$14.15	$23.10	$36.75	$57.75	$117.00
$60,000	$3.60	$4.62	$7.20	$10.80	$16.98	$27.72	$44.10	$69.30	$140.40
$70,000	$4.20	$5.39	$8.40	$12.60	$19.81	$32.34	$51.45	$80.85	$163.80
$80,000	$4.80	$6.16	$9.60	$14.40	$22.64	$36.96	$58.80	$92.40	$187.20
$90,000	$5.40	$6.93	$10.80	$16.20	$25.47	$41.58	$66.15	$103.95	$210.60
$100,000	$6.00	$7.70	$12.00	$18.00	$28.30	$46.20	$73.50	$115.50	$234.00
$150,000	$9.00	$11.55	$18.00	$27.00	$42.45	$69.30	$110.25	$173.25	$351.00
$200,000	$12.00	$15.40	$24.00	$36.00	$56.60	$92.40	$147.00	$231.00	$468.00
$250,000	$15.00	$19.25	$30.00	$45.00	$70.75	$115.50	$183.75	$288.75	$585.00
$300,000	$18.00	$23.10	$36.00	$54.00	$84.90	$138.60	$220.50	$346.50	$702.00
$350,000	$21.00	$26.95	$42.00	$63.00	$99.05	$161.70	$257.25	$404.25	$819.00
$400,000	$24.00	$30.80	$48.00	$72.00	$113.20	$184.80	$294.00	$462.00	$936.00
$450,000	$27.00	$34.65	$54.00	$81.00	$127.35	$207.90	$330.75	$519.75	$1,053.00
$500,000	$30.00	$38.50	$60.00	$90.00	$141.50	$231.00	$367.50	$577.50	$1,170.00
$550,000	$33.00	$42.35	$66.00	$99.00	$155.65	$254.10	$404.25	$635.25	$1,287.00
$600,000	$36.00	$46.20	$72.00	$108.00	$169.80	$277.20	$441.00	$693.00	$1,404.00
$650,000	$39.00	$50.05	$78.00	$117.00	$183.95	$300.30	$477.75	$750.75	$1,521.00
$700,000	$42.00	$53.90	$84.00	$126.00	$198.10	$323.40	$514.50	$808.50	$1,638.00
$750,000	$45.00	$57.75	$90.00	$135.00	$212.25	$346.50	$551.25	$866.25	$1,755.00

Premium is based on employee's and/or spouse's prior years age and will be adjusted on January 1 as the age bracket changes.

Child Optional Benefits - Child Optional Benefits can be purchased in increments of $2,500 to a maximum of $10,000. Children are covered from 14 days to age 26.

Child Optional Monthly Costs - Child Optional Life Premium is $.235 per $1,000

Amount of Coverage	Monthly Cost
$2,500	$0.59
$5,000	$1.18
$7,500	$1.76
$10,000	$2.35

October 2016

2018 REQUIRED NOTICES

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 **1-877-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 **1-866-444-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 August 10, 2017. Contact your State for more information on eligibility –

ALABAMA – Medicaid	**FLORIDA – Medicaid**
Website: http://myalhipp.com/ Phone: 1-855-692-5447	Website: http://flmedicaidtplrecovery.com/hipp/ Phone: 1-877-357-3268
ALASKA – Medicaid	**GEORGIA – Medicaid**
The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx	Website: http://dch.georgia.gov/medicaid - Click on Health Insurance Premium Payment (HIPP) Phone: 404-656-4507
ARKANSAS – Medicaid	**INDIANA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: http://www.indianamedicaid.com Phone 1-800-403-0864
COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	**IOWA – Medicaid**

Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+: Colorado.gov/HCPF/Child-Health-Plan-Plus CHP+ Customer Service: 1-800-359-1991/ State Relay 711	Website: http://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp Phone: 1-888-346-9562

KANSAS – Medicaid	NEW HAMPSHIRE – Medicaid
Website: http://www.kdheks.gov/hcf/ Phone: 1-785-296-3512	Website: http://www.dhhs.nh.gov/oii/documents/hippapp.pdf Phone: 603-271-5218
KENTUCKY – Medicaid	**NEW JERSEY – Medicaid and CHIP**
Website: http://chfs.ky.gov/dms/default.htm Phone: 1-800-635-2570	Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710
LOUISIANA – Medicaid	**NEW YORK – Medicaid**
Website: http://dhh.louisiana.gov/index.cfm/subhome/1/n/331 Phone: 1-888-695-2447	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
MAINE – Medicaid	**NORTH CAROLINA – Medicaid**
Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html Phone: 1-800-442-6003 TTY: Maine relay 711	Website: https://dma.ncdhhs.gov/ Phone: 919-855-4100
MASSACHUSETTS – Medicaid and CHIP	**NORTH DAKOTA – Medicaid**
Website: http://www.mass.gov/eohhs/gov/departments/masshealth/ Phone: 1-800-862-4840	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825
MINNESOTA – Medicaid	**OKLAHOMA – Medicaid and CHIP**
Website: http://mn.gov/dhs/people-we-serve/seniors/health-care/health-care-programs/programs-and-services/medical-assistance.jsp Phone: 1-800-657-3739	Website: http://www.insureoklahoma.org Phone: 1-888-365-3742
MISSOURI – Medicaid	**OREGON – Medicaid**
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075
MONTANA – Medicaid	**PENNSYLVANIA – Medicaid**
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084	Website: http://www.dhs.pa.gov/provider/medicalassistance/healthinsurancepremiumpaymenthippprogram/index.htm

	Phone: 1-800-692-7462
NEBRASKA – Medicaid	**RHODE ISLAND – Medicaid**
Website: http://www.ACCESSNebraska.ne.gov Phone: (855) 632-7633 Lincoln: (402) 473-7000 Omaha: (402) 595-1178	Website: http://www.eohhs.ri.gov/ Phone: 855-697-4347
NEVADA – Medicaid	**SOUTH CAROLINA – Medicaid**
Medicaid Website: https://dwss.nv.gov/ Medicaid Phone: 1-800-992-0900	Website: https://www.scdhhs.gov Phone: 1-888-549-0820

SOUTH DAKOTA - Medicaid	**WASHINGTON – Medicaid**
Website: http://dss.sd.gov Phone: 1-888-828-0059	Website: http://www.hca.wa.gov/free-or-low-cost-health-care/program-administration/premium-payment-program Phone: 1-800-562-3022 ext. 15473
TEXAS – Medicaid	**WEST VIRGINIA – Medicaid**
Website: http://gethipptexas.com/ Phone: 1-800-440-0493	Website: http://mywvhipp.com/ Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
UTAH – Medicaid and CHIP	**WISCONSIN – Medicaid and CHIP**
Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669	Website: https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf Phone: 1-800-362-3002
VERMONT– Medicaid	**WYOMING – Medicaid**
Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427	Website: https://wyequalitycare.acs-inc.com/ Phone: 307-777-7531
VIRGINIA – Medicaid and CHIP	
Medicaid Website: http://www.coverva.org/programs_premium_assistance.cfm Medicaid Phone: 1-800-432-5924 CHIP Website: http://www.coverva.org/programs_premium_assistance.cfm CHIP Phone: 1-855-242-8282	

To see if any other states have added a premium assistance program since August 10, 2017, or for more information on special enrollment rights, contact either:

U.S. Department of Labor / U.S. Department of Health and Human Services
Employee Benefits Security Administration
Centers for Medicare & Medicaid Services
www.dol.gov/agencies/ebsa **www.cms.hhs.gov**
1-866-444-EBSA (3272) 1-877-267-2323, Menu Option 4, Ext. 61565

Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0137.

OMB Control Number 1210-0137 (expires 12/31/2019)

WOMEN'S HEALTH AND 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 stages 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 physical 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 this plan. If you would like more information on WHCRA benefits, call your plan administrator.

SPECIAL ENROLLMENT NOTICE

This notice is being provided to insure that you understand your right to apply for group insurance coverage. You should read this notice even if you plan to waive coverage at this time.

Loss of Other Coverage: If you are declining coverage for yourself, or your eligible dependents (including your spouse), because of other insurance coverage, you may be able to enroll yourself and your eligible dependents in this plan if you, or your dependents, lose eligibility from that other coverage (or if the employer stops contributing toward you or your dependents' other coverage). However, you must request enrollment within 30 days after you, or your dependents' other coverage ends (or after the employer stops contributing **toward the other coverage).**

Example: You waived coverage because you were covered under a plan offered by your spouse's employer. Your spouse terminates his/her employment. If you notify your employer within 30 days of the date of the qualifying event, you and your eligible dependents may apply for coverage under your employer's plan.

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

Example: When you were hired, you were single and chose not to elect insurance benefits. One year later, you marry. You and your eligible dependents are entitled to enroll in the group plans. However, you must apply within 30 days from the date of the qualifying event, your marriage.

Medicaid or CHIP: If you or your dependents lose eligibility for coverage under Medicaid or the Children's Health Insurance Program (CHIP) or become eligible for a premium assistance subsidy under Medicaid or CHIP, you may be able to enroll yourself and

your dependents. You must request enrollment within 60 days of the loss of Medicaid or CHIP coverage or the determination of eligibility for a premium assistance subsidy.

Example: When you were hired, your children received health coverage under CHIP and you did not enroll them in the health plan. Because of changes in your income, your children are no longer eligible for CHIP coverage. You may enroll them in this group health plan if you apply within 60 days of the date of their qualifying event, loss of CHIP coverage.

Lake Land College
Human Resources
5001 Lake Land Blvd.
Mattoon, IL 61938
humanresources@lakelandcollege.edu

IMPORTANT NOTICE FROM LAKE LAND COLLEGE ABOUT YOUR PRESCRIPTION DRUG COVERAGE AND MEDICARE

CREDITABLE

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage 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. Your carrier has determined that the prescription drug coverage currently offered is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered **Creditable Coverage**. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?
You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?
If you decide to join a Medicare drug plan, your current coverage will not be affected.

You can keep your coverage if you elect Medicare Part D.

If you do decide to join a Medicare drug plan and drop your current coverage, you and your dependents will be able to get this coverage back with a qualifying event or at open enrollment.

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 and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For More Information About This Notice Or Your Current Prescription Drug Coverage…
Contact the person listed below for further information. **NOTE:** You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if your current coverage changes. You also may request a copy of this notice at any time.
For More Information About Your Options Under Medicare Prescription Drug Coverage…
More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help

- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

Name of Entity/Sender:

Lake Land College
Human Resources
5001 Lake Land Blvd.
Mattoon, IL 61938
humanresources@lakelandcollege.edu

CMS Form 10182-CC Updated April 1, 2011

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0990. The time required to complete this information collection is estimated to average 8 hours per response initially, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

COBRA CONTINUATION COVERAGE RIGHTS NOTICE

Introduction

You are receiving this notice because you have recently become covered under a group health plan. This notice contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive 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 when you would otherwise lose your group health coverage. It can also become available to other members of your family who are covered under the Plan when they would otherwise lose their group health coverage. For additional 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 coverage would otherwise end because of a life event known as 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 are an employee, you will become a qualified beneficiary if you lose your coverage under the plan because either one of the following qualifying events happens:

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

If you are the spouse of an employee, you will become a qualified beneficiary if you lose your coverage under the plan because any of the following qualifying events happens:

- 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 any of the following qualifying events happens:

- 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 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. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee, or the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), the employer must notify the Plan Administrator of the qualifying event.

You Must Give Notice of Some Qualifying Events
For the 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 your employer.

How is COBRA 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. When the qualifying event is the death of the employee, the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), your divorce or legal separation, or a dependent child's losing eligibility as a dependent child, COBRA continuation coverage lasts for up to a total of 36 months. When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA continuation coverage for his spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months). Otherwise, when the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

Disability extension of 18-month period of continuation coverage
If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total 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 continuation coverage. Notification to extend coverage due to disability and Social Security's Determination of Disability must be received by the insurance carrier within 60 days from the date of notification from Social Security Disability and prior to the end of the 18 month COBRA term. In order for the employer to notify the insurance carrier of your right to continue coverage for an additional 11 months, your notification and Social Security's Determination of Disability must be provided to the individual noted below within 60 days from the date of notification from Social Security Disability and prior to the end of your 18 month COBRA term.

Second qualifying event extension of 18-month period of continuation coverage
If your family experiences another qualifying event while receiving 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 notice of the second qualifying event is properly given to the Plan. This extension may be available to the spouse and any dependent children receiving continuation coverage if the employee or former employee dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), or gets divorced or legally separated, or if the dependent child stops being eligible under the Plan as a dependent child, but only if the event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

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 ERISA, including COBRA, the Patient Protection and Affordable Care Act, the Health Insurance

Portability and Accountability Act (HIPAA), 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 the EBSA website at 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 Informed of Address Changes
In order to protect your family's rights, you should keep the Plan Administrator informed of 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

Lake Land College
Human Resources
5001 Lake Land Blvd.
Mattoon, IL 61938
humanresources@lakelandcollege.edu

NEW HEALTH INSURANCE MARKETPLACE COVERAGE OPTIONS AND YOUR HEALTH COVERAGE

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.

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. The 2018 open enrollment period for health insurance coverage through the Marketplace runs from Nov. 1, 2017 through Dec. 31, 2017. You should apply for coverage prior to Dec. 15, 2017 if you want coverage to be effective Jan. 1, 2018. After Dec. 17, 2016, insurance likely won't start until Feb. 1, 2018. You cannot get coverage through the Marketplace outside the annual enrollment period unless you have a special "life event".

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 9.66% 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 the **Lake Land College.**

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 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 your 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.

1. Employer name Lake Land College	2. Employer Identification Number (EIN) 37-0896233
3. Employer address 5001 Lake Land Blvd.	4. Employer phone number 217-234-5000

5. City	6. State	7. ZIP code
Mattoon	IL	61938

8. Who can we contact about employee health coverage at this job?	
Human Resources	
9. Phone number (if different from above)	10. Email address
	humanresources@lakelandcollege.edu

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

As your employer, we offer a health plan to:

☐ All employees.

X Some employees.

Eligible employees are: Full time employees or those that average 30 or more hours a week during a 6 month measurement period.

With respect to dependents:

X We do offer coverage.
Eligible dependents are: Spouse, children to age 26 and children over age 26 who meet eligibility requirements, are mentally / physically incapable of earning a living and dependent on subscriber or spouse for support and maintenance.

☐ We do not offer coverage.

x If checked, this coverage meets the minimum value standard, and the cost of the 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 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. This is 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.

PRIVACY PRACTICES NOTICE

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

Our Company's Pledge to You
This notice is intended to inform you of the privacy practices followed by the **Lake Land College** (the Plan) and the Plan's legal obligations regarding your protected health information under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). The notice also explains the privacy rights you and your family members have as participants of the Plan.

The Plan often needs access to your protected health information in order to provide payment for health services and perform plan administrative functions. We want to assure the plan participants covered under the Plan that we comply with federal privacy laws and respect your right to privacy. **Lake Land College** requires all members of our workforce and third parties that are provided access to protected health information to comply with the privacy practices outlined below.

Protected Health Information
Your protected health information is protected by the HIPAA Privacy Rule. Generally, protected health information is information that identifies an individual created or received by a health care provider, health plan or an employer on behalf of a group health plan that relates to physical or mental health conditions, provision of health care, or payment for health care, whether past, present or future.

How We May Use Your Protected Health Information
Under the HIPAA Privacy Rule, we may use or disclose your protected health information for certain purposes without your permission. This section describes the ways we can use and disclose your protected health information.

Payment. We use or disclose your protected health information without your written authorization in order to determine eligibility for benefits, seek reimbursement from a third party, or coordinate benefits with another health plan under which you are covered. For example, a health care provider that provided treatment to you will provide us with your health information. We use that information in order to determine whether those services are eligible for payment under our group health plan.

Health Care Operations. We use and disclose your protected health information in order to perform plan administration functions such as quality assurance activities, resolution of internal grievances, and evaluating plan performance. For example, we review claims experience in order to understand participant utilization and to make plan design changes that are intended to control health care costs.

Treatment. Although the law allows use and disclosure of your protected health information for purposes of treatment, as a health plan we generally do not need to disclose your information for treatment purposes. Your physician or health care provider is required to provide you with an explanation of how they use and share your health information for purposes of treatment, payment, and health care operations.

As permitted or required by law. We may also use or disclose your protected health information without your written authorization for other reasons as *permitted* by law. We are *permitted* by law to share information, subject to certain requirements, in order to communicate information on health-related benefits or services that may be of interest to you, respond to a court order, or provide information to further public health activities (e.g., preventing the spread of disease) without your written authorization. We are also permitted to share protected health information during a corporate restructuring such as a merger, sale, or acquisition. We will also disclose health information about you when *required* by law, for example, in order to prevent serious harm to you or others.

Pursuant to your Authorization. When required by law, we will ask for your written authorization before using or disclosing your protected health information. If you choose to sign an authorization to disclose information, you can later revoke that authorization to prevent any future uses or disclosures.

To Business Associates. We may enter into contracts with entities known as Business Associates that provide services to or perform functions on behalf of the Plan. We may disclose protected health information to Business Associates once they have agreed in writing to safeguard the protected health information. For example, we may disclose your protected health information to a Business Associate to administer claims. Business Associates are also required by law to protect protected health information.

To the Plan Sponsor. We may disclose protected health information to certain employees of **Lake Land College** for the purpose of administering the Plan. These employees will use or disclose the protected health information only as necessary to perform plan administration functions or as otherwise required by HIPAA, unless you have authorized additional disclosures. Your protected health information cannot be used for employment purposes without your specific authorization.

Your Rights

Right to Inspect and Copy. In most cases, you have the right to inspect and copy the protected health information we maintain about you. If you request copies, we will charge you a reasonable fee to cover the costs of copying, mailing, or other expenses associated with your request. Your request to inspect or review your health information must be submitted in writing to the person listed below. In some circumstances, we may deny your request to inspect and copy your health information. To the extent your information is held in an electronic health record, you may be able to receive the information in an electronic format.

Right to Amend. If you believe that information within your records is incorrect or if important information is missing, you have the right to request that we correct the existing information or add the missing information. Your request to amend your health information must be submitted in writing to the person listed below. In some circumstances, we may deny your request to amend your health information. If we deny

your request, you may file a statement of disagreement with us for inclusion in any future disclosures of the disputed information.

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

Your request to for an accounting must be submitted in writing to the person listed below. You may request an accounting of disclosures made within the last six years. You may request one accounting free of charge within a 12-month period.

Right to Request Restrictions. You have the right to request that we not use or disclose information for treatment, payment, or other administrative purposes except when specifically authorized by you, when required by law, or in emergency circumstances. You also have the right to request that we limit the protected health information that we disclose to someone involved in your care or the payment for your care, such as a family member or friend.

Your request for restrictions must be submitted in writing to the person listed below. We will consider your request, but in most cases are not legally obligated to agree to those restrictions. However, we will comply with any restriction request if the disclosure is to a health plan for purposes of payment or health care operations (not for treatment) and the protected health information pertains solely to a health care item or service that has been paid for out-of-pocket and in full.

Right to Request Confidential Communications. You have the right to receive confidential communications containing your health information. Your request for restrictions must be submitted in writing to the person listed below. We are required to accommodate reasonable requests. For example, you may ask that we contact you at your place of employment or send communications regarding treatment to an alternate address.

Right to be Notified of a Breach. You have the right to be notified in the event that we (or one of our Business Associates) discover a breach of your unsecured protected health information. Notice of any such breach will be made in accordance with federal requirements.

Right to Receive a Paper Copy of this Notice. If you have agreed to accept this notice electronically, you also have a right to obtain a paper copy of this notice from us upon request. To obtain a paper copy of this notice, please contact the person listed below.

Our Legal Responsibilities

We are required by law to protect the privacy of your protected health information, provide you with certain rights with respect to your protected health information, provide you with this notice about our privacy practices, and follow the information practices that are described in this notice.

We may change our policies at any time. In the event that we make a significant change in our policies, we will provide you with a revised copy of this notice. You can also request a copy of our notice at any time. For more information about our privacy practices, contact the person listed below.

If you have any questions or complaints, please contact:

Lake Land College
Human Resources
5001 Lake Land Blvd.
Mattoon, IL 61938
humanresources@lakelandcollege.edu

Complaints

If you are concerned that we have violated your privacy rights, or you disagree with a decision we made about access to your records, you may contact the person listed above. You also may send a written complaint to the U.S. Department of Health and Human Services — Office of Civil Rights. The person listed above can provide you with the appropriate address upon request or you may visit www.hhs.gov/ocr for further information. You will not be penalized or retaliated against for filing a complaint with the Office of Civil Rights or with us.

NOTICE REGARDING WELLNESS PROGRAM

The Lake Land College Wellness program is a voluntary wellness program available to all employees. The program is administered according to federal rules permitting employer-sponsored wellness programs that seek to improve employee health or prevent disease, including the Americans with Disabilities Act of 1990, the Genetic Information Nondiscrimination Act of 2008, and the Health Insurance Portability and Accountability Act, as applicable, among others. If you choose to participate in the wellness program you will be asked to complete a voluntary health risk assessment or "HRA" that asks a series of questions about your health-related activities and behaviors and whether you have or had certain medical conditions (e.g., cancer, diabetes, or heart disease). You will also be asked to complete a biometric screening, which will include a blood test to screen for chronic diseases such as heart disease and diabetes. You are not required to complete the HRA or to participate in the blood test or other medical examinations.

However, employees who choose to participate in the wellness program will receive an incentive of $50 per month per employee ($75 per month per custodial association employees) for completing the health assessment and up to $400 per year for participating in the Fresh Start program. Although you are not required to complete the HRA or participate in the biometric screening, only employees who complete the do so will receive the incentive.

Additional incentives may be available for employees who participate in certain health-related activities such as educational programs and walking programs or achieve certain health outcomes such as improvement in blood sugar through the Fresh Start program. If you are unable to participate in any of the health-related activities or achieve any of the health outcomes required to earn an incentive, you may be entitled to a reasonable accommodation or an alternative standard. You may request a reasonable accommodation or an alternative standard by contacting **Human Resources** at **217-234-5000**.

The information from your HRA and the results from your biometric screening will be used to provide you with information to help you understand your current health and potential risks, and may also be used to offer you services through the wellness program, such as online programs and health coaching. You also are encouraged to share your results or concerns with your own doctor.

Protections from Disclosure of Medical Information

We are required by law to maintain the privacy and security of your personally identifiable health information. Although the wellness program and Lake Land College may use aggregate information it collects to design a program based on identified health risks in the workplace, the Lake Land College Wellness program will never disclose any of your personal information either publicly or to the employer, except as necessary to respond to a request from you for a reasonable accommodation needed to participate in the wellness program, or as expressly permitted by law. Medical information that personally identifies you that is provided in connection with the wellness program will not be provided to your supervisors or managers and may never be used to make decisions regarding your employment.

Your health information will not be sold, exchanged, transferred, or otherwise disclosed except to the extent permitted by law to carry out specific activities related to the wellness program, and you will not be asked or required to waive the confidentiality of your health information as a condition of participating in the wellness program or receiving an incentive. Anyone who receives your information for purposes of providing you services as part of the wellness program will abide by the same confidentiality requirements. The only individual(s) who will receive your personally identifiable health information is a health coach in order to provide you with services under the wellness program.

In addition, all medical information obtained through the wellness program will be maintained separate from your personnel records, information stored electronically will be encrypted, and no information you provide as part of the wellness program will be used in making any employment decision. Appropriate precautions will be taken to avoid any data breach, and in the event a data breach occurs involving information you provide in connection with the wellness program, we will notify you immediately.

You may not be discriminated against in employment because of the medical information you provide as part of participating in the wellness program, nor may you be subjected to retaliation if you choose not to participate.

If you have questions or concerns regarding this notice, or about protections against discrimination and retaliation, please contact **Human Resources** at **217-234-5000.**

Summary of Benefits and Coverage: What this Plan Covers & What You Pay for Covered Services

Coverage Period: 01/01/2018-12/31/2018

Coverage for: Individual + Family | **Plan Type:** POS

aetna : LAKE LAND COLLEGE : Aetna Choice® POS II - Traditional

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, www.HealthReformPlanSBC.com or by calling 1-888-982-3862. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at https://www.healthcare.gov/sbc-glossary/ or call 1-888-982-3862 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Network: Individual $1,000 / Family $2,000. Out-of-Network: Individual $1,750 / Family $3,500.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Emergency care & prescription drugs; plus in-network office visits & preventive care are covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	Network: Individual $2,500 / Family $5,000. Out-of-Network: Individual $4,750 / Family $9,500.	The out–of–pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out–of–pocket limits until the overall family out–of–pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges, health care this plan doesn't cover & penalties for failure to obtain pre-authorization for services.	Even though you pay these expenses, they don't count toward the out–of–pocket limit.
Will you pay less if you use a network provider?	Yes. See www.aetna.com/docfind or call 1-888-982-3862 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$25 copay/visit, deductible doesn't apply	30% coinsurance	None
	Specialist visit	$35 copay/visit, deductible doesn't apply	30% coinsurance	None
	Preventive care /screening /immunization	No charge	30% coinsurance	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	10% coinsurance	30% coinsurance	None
	Imaging (CT/PET scans, MRIs)	10% coinsurance	30% coinsurance	None
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.aetnapharmacy.com/premierplus Premier Plus Formulary	Generic drugs	Copay/prescription, deductible doesn't apply: $10 (retail), $20 (mail order)	30% coinsurance after copay/prescription, deductible doesn't apply: $10 (retail)	Covers 30 day supply (retail), 31-90 day supply (mail order). Includes contraceptive drugs & devices obtainable from a pharmacy, oral fertility drugs. No charge for preferred generic FDA-approved women's contraceptives in-network. Your cost will be higher for choosing Brand over Generics.
	Preferred brand drugs	Copay/prescription, deductible doesn't apply: $25 (retail), $40 (mail order)	30% coinsurance after copay/prescription, deductible doesn't apply: $25 (retail)	
	Non-preferred brand drugs	Copay/prescription, deductible doesn't apply: $40 (retail), $70 (mail order)	30% coinsurance after copay/prescription, deductible doesn't apply: $40 (retail)	
	Specialty drugs	Copay/prescription, deductible doesn't apply: $70	Not covered	First prescription fill at a retail pharmacy or specialty pharmacy. Subsequent fills must be through the Aetna Specialty Pharmacy Network. Precertification required for coverage.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% coinsurance	30% coinsurance	None
	Physician/surgeon fees	10% coinsurance	30% coinsurance	None
If you need immediate medical attention	Emergency room care	10% coinsurance, deductible doesn't apply	10% coinsurance, deductible doesn't apply	10% coinsurance in-network & 30% coinsurance out-of-network for non-emergency use.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Emergency medical transportation	10% coinsurance	10% coinsurance	30% coinsurance for out-of-network non-emergency transport.
	Urgent care	$20 copay/visit, deductible doesn't apply	30% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance	30% coinsurance	Penalty of $1,000 for failure to obtain pre-authorization for out-of-network care.
	Physician/surgeon fees	10% coinsurance	30% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office & other outpatient services: $20 copay/visit, deductible doesn't apply	Office & other outpatient services: 30% coinsurance	None
	Inpatient services	10% coinsurance	30% coinsurance	Penalty of $1,000 for failure to obtain pre-authorization for out-of-network care.
If you are pregnant	Office visits	No charge	30% coinsurance	Cost sharing does not apply for preventive services. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.) Penalty of $1,000 for failure to obtain pre-authorization for out-of-network care may apply.
	Childbirth/delivery professional services	10% coinsurance	30% coinsurance	
	Childbirth/delivery facility services	10% coinsurance	30% coinsurance	
If you need help recovering or have other special health needs	Home health care	10% coinsurance	30% coinsurance	60 visits/calendar year. Penalty of $1,000 for failure to obtain pre-authorization for out-of-network care.
	Rehabilitation services	10% coinsurance	30% coinsurance	None
	Habilitation services	10% coinsurance	30% coinsurance	Limited to treatment of Autism.
	Skilled nursing care	10% coinsurance	30% coinsurance	60 days/calendar year. Penalty of $1,000 for failure to obtain pre-authorization for out-of-network care.
	Durable medical equipment	10% coinsurance	30% coinsurance	Limited to 1 durable medical equipment for same/similar purpose. Excludes repairs for misuse/abuse.
	Hospice services	10% coinsurance	30% coinsurance	Penalty of $1,000 for failure to obtain pre-authorization for out-of-network care.
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	Not covered.
	Children's glasses	Not covered	Not covered	Not covered.
	Children's dental check-up	Not covered	Not covered	Not covered.

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

• Acupuncture • Bariatric surgery • Cosmetic surgery • Dental care (Adult & Child)	• Glasses (Child) • Hearing aids • Long-term care • Non-emergency care when traveling outside the U.S.	• Routine eye care (Adult & Child) • Routine foot care • Weight loss programs - Except for required preventive services.

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Chiropractic care - 20 visits/calendar year.	• Infertility treatment - Limited to the diagnosis & treatment of underlying medical condition.	• Private-duty nursing

Your Rights to Continue Coverage:

There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is:

- F
  or more information on your rights to continue coverage, contact the plan at 1-888-982-3862.
- If your group health coverage is subject to ERISA, you may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.
- For non-federal governmental group health plans, you may also contact the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov.
- If your coverage is a church plan, church plans are not covered by the Federal COBRA continuation coverage rules. If the coverage is insured, individuals should contact their State insurance regulator regarding their possible rights to continuation coverage under State law.

Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights:

There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact:

- Aetna directly by calling the toll free number on your Medical ID Card, or by calling our general toll free number at 1-888-982-3862.
- If your group health coverage is subject to ERISA, you may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.
- For non-federal governmental group health plans, you may also contact the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov.
- Additionally, a consumer assistance program can help you file your appeal. Contact information is at: http://www.aetna.com/individuals-families-health-insurance/rights-resources/complaints-grievances-appeals/index.html.

Does this plan provide Minimum Essential Coverage? Yes.

If you don't have **Minimum Essential Coverage** for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet Minimum Value Standard? Yes.

If your **plan** doesn't meet the **Minimum Value Standards**, you may be eligible for a **premium tax credit** to help you pay for a **plan** through the **Marketplace.**

----------*To see examples of how this plan might cover costs for a sample medical situation, see the next section.*----------

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this **plan** might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your **providers** charge, and many other factors. Focus on the **cost sharing** amounts (**deductibles**, **copayments** and **coinsurance**) and **excluded services** under the **plan**. Use this information to compare the portion of costs you might pay under different health **plans**. Please note these coverage examples are based on self-only coverage.

Total Example Cost	**$12,800**

Peg is Having a Baby

(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	**$1,000**
Specialist copayment	**$35**
Hospital (facility) coinsurance	**10%**
Other coinsurance	**10%**

This EXAMPLE event includes services like:
Specialist office visits (*prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,800**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$1,000
Copayments	$80
Coinsurance	$1,100
What isn't covered	
Limits or exclusions	$60

Managing Joe's type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

The total Peg would pay is	**$2,240**

Note: These numbers assume the patient does not participate in the plan's wellness program. If you participate in the plan's w
more information about the wellness program, please contact: 1-888-[illegible].

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

The plan's overall deductible	**$1,000**
Specialist copayment	**$35**
Hospital (facility) coinsurance	**10%**
Other coinsurance	**10%**

This EXAMPLE event includes services like:
Primary care physician office visits *(including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$100
Copayments	$1,200
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20

Total Example Cost	**$7,400**
The total Joe would pay is	**$1,320**

- **The plan's overall deductible** **$1,000**
- **Specialist copayment** **$35**
- **Hospital (facility) coinsurance** **10%**
- **Other coinsurance** **10%**

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$1,900**
In this example, Mia would pay:	
Cost Sharing	
Deductibles	$800
Copayments	$70
Coinsurance	$80
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$950**

l be responsible for the other costs of these EXAMPLE covered services.

Assistive Technology

Persons using assistive technology may not be able to fully access the following information. For assistance, please call 1-888-982-3862.

Smartphone or Tablet

To view documents from your smartphone or tablet, the free WinZip app is required. It may be available from your App Store.

Non-Discrimination

Aetna complies with applicable Federal civil rights laws and does not discriminate, exclude or treat people differently based on their race, color, national origin, sex, age, or disability.

Aetna provides free aids/services to people with disabilities and to people who need language assistance.

If you need a qualified interpreter, written information in other formats, translation or other services, call the number on your ID card.

If you believe we have failed to provide these services or otherwise discriminated based on a protected class noted above, you can also file a grievance with the Civil Rights Coordinator by contacting:

Civil Rights Coordinator,

P.O. Box 14462, Lexington, KY 40512 (CA HMO customers: PO Box 24030 Fresno, CA 93779),

1-800-648-7817, TTY: 711, Fax: 859-425-3379 (CA HMO customers: 1-860-262-7705),

Email: CRCoordinator@aetna.com.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, or at 1-800-368-1019, 800-537-7697 (TDD).

Aetna is the brand name used for products and services provided by one or more of the Aetna group of subsidiary companies, including Aetna Life Insurance Company, Coventry Health Care plans and their affiliates (Aetna).

Summary of Benefits and Coverage: What this Plan Covers & What You Pay for Covered Services

aetna : LAKE LAND COLLEGE : Aetna Choice® POS II - HDHP

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, www.HealthReformPlanSBC.com or by calling 1-888-982-3862. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at https://www.healthcare.gov/sbc-glossary/ or call 1-888-982-3862 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Network: EE Only $2,250; EE+ Family $4,500. Out-of-Network: EE Only $4,250; EE+ Family $8,500.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the policy, the overall family deductible must be met before the plan begins to pay.
Are there services covered before you meet your deductible?	Yes. In-network preventive care is covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	Network: EE Only $4,250; EE+ Family $7,050. Out-of-Network: EE Only $8,250; EE+ Family $16,500.	The out–of–pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, the overall family out–of–pocket limit must be met.
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges, health care this plan doesn't cover & penalties for failure to obtain pre-authorization for services.	Even though you pay these expenses, they don't count toward the out–of–pocket limit.
Will you pay less if you use a network provider?	Yes. See www.aetna.com/docfind or call 1-888-982-3862 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	10% coinsurance	30% coinsurance	None
	Specialist visit	10% coinsurance	30% coinsurance	None
	Preventive care /screening /immunization	No charge	30% coinsurance	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	10% coinsurance	30% coinsurance	None
	Imaging (CT/PET scans, MRIs)	10% coinsurance	30% coinsurance	None
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.aetnapharmacy.com/premierplus Premier Plus Formulary	Generic drugs	10% coinsurance	30% coinsurance (retail)	Covers 30 day supply (retail), 31-90 day supply (mail order). Includes contraceptive drugs & devices obtainable from a pharmacy, oral fertility drugs. No charge for preferred generic FDA-approved women's contraceptives in-network. Your cost will be higher for choosing Brand over Generics.
	Preferred brand drugs	10% coinsurance	30% coinsurance (retail)	
	Non-preferred brand drugs	10% coinsurance	30% coinsurance (retail)	
	Specialty drugs	Applicable cost as noted above for generic or brand drugs	Not covered	First prescription fill at a retail pharmacy or specialty pharmacy. Subsequent fills must be through the Aetna Specialty Pharmacy Network. Precertification required for coverage.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% coinsurance	30% coinsurance	None
	Physician/surgeon fees	10% coinsurance	30% coinsurance	None
If you need immediate medical attention	Emergency room care	10% coinsurance	10% coinsurance	10% coinsurance in-network & 30% coinsurance out-of-network for non-emergency use.
	Emergency medical transportation	10% coinsurance	10% coinsurance	None
	Urgent care	10% coinsurance	30% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance	30% coinsurance	Penalty of $1,000 for failure to obtain pre-authorization for out-of-network care.
	Physician/surgeon fees	10% coinsurance	30% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office & other outpatient services: 10% coinsurance	Office & other outpatient services: 30% coinsurance	None
	Inpatient services	10% coinsurance	30% coinsurance	Penalty of $1,000 for failure to obtain pre-authorization for out-of-network care.
If you are pregnant	Office visits	No charge	30% coinsurance	Cost sharing does not apply for preventive services.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Childbirth/delivery professional services	10% coinsurance	30% coinsurance	Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.) Penalty of $1,000 for failure to obtain pre-authorization for out-of-network care may apply.
	Childbirth/delivery facility services	10% coinsurance	30% coinsurance	
If you need help recovering or have other special health needs	Home health care	10% coinsurance	30% coinsurance	60 visits/calendar year. Penalty of $1,000 for failure to obtain pre-authorization for out-of-network care.
	Rehabilitation services	10% coinsurance	30% coinsurance	None
	Habilitation services	10% coinsurance	30% coinsurance	Limited to treatment of Autism.
	Skilled nursing care	10% coinsurance	30% coinsurance	60 days/calendar year. Penalty of $1,000 for failure to obtain pre-authorization for out-of-network care.
	Durable medical equipment	10% coinsurance	30% coinsurance	Limited to 1 durable medical equipment for same/similar purpose. Excludes repairs for misuse/abuse.
	Hospice services	10% coinsurance	30% coinsurance	Penalty of $1,000 for failure to obtain pre-authorization for out-of-network care.
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	Not covered.
	Children's glasses	Not covered	Not covered	Not covered.
	Children's dental check-up	Not covered	Not covered	Not covered.

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Acupuncture
- Bariatric surgery
- Cosmetic surgery
- Dental care (Adult & Child)
- Glasses (Child)
- Hearing aids
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Routine eye care (Adult & Child)
- Routine foot care
- Weight loss programs - Except for required preventive services.

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Chiropractic care - 20 visits/calendar year.
- Infertility treatment - Limited to the diagnosis & treatment of underlying medical condition.
- Private-duty nursing

Your Rights to Continue Coverage:

There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is:

- F
  or more information on your rights to continue coverage, contact the plan at 1-888-982-3862.
- If your group health coverage is subject to ERISA, you may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.
- For non-federal governmental group health plans, you may also contact the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov.
- If your coverage is a church plan, church plans are not covered by the Federal COBRA continuation coverage rules. If the coverage is insured, individuals should contact their State insurance regulator regarding their possible rights to continuation coverage under State law.

Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights:

There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact:

- Aetna directly by calling the toll free number on your Medical ID Card, or by calling our general toll free number at 1-888-982-3862.
- If your group health coverage is subject to ERISA, you may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.
- For non-federal governmental group health plans, you may also contact the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov.
- Additionally, a consumer assistance program can help you file your appeal. Contact information is at: http://www.aetna.com/individuals-families-health-insurance/rights-resources/complaints-grievances-appeals/index.html.

Does this plan provide Minimum Essential Coverage? Yes.

If you don't have **Minimum Essential Coverage** for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet Minimum Value Standard? Yes.

If your **plan** doesn't meet the **Minimum Value Standards**, you may be eligible for a **premium tax credit** to help you pay for a **plan** through the **Marketplace.**

----------*To see examples of how this plan might cover costs for a sample medical situation, see the next section.*----------

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this **plan** might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your **providers** charge, and many other factors. Focus on the **cost sharing** amounts (**deductibles**, **copayments** and **coinsurance**) and **excluded services** under the **plan**. Use this information to compare the portion of costs you might pay under different health **plans**. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	**$2,250**
Specialist coinsurance	**10%**
Hospital (facility) coinsurance	**10%**
Other coinsurance	**10%**

This EXAMPLE event includes services like:
Specialist office visits *(prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests *(ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,800**
In this example, Peg would pay:	
Cost Sharing	
Deductibles	$2,250
Copayments	$0
Coinsurance	$1,000
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$3,310**

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	**$2,250**
Specialist coinsurance	**10%**
Hospital (facility) coinsurance	**10%**
Other coinsurance	**10%**

This EXAMPLE event includes services like:
Primary care physician office visits *(including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$7,400**
In this example, Joe would pay:	
Cost Sharing	
Deductibles	$2,250
Copayments	$0
Coinsurance	$500
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$2,770**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	**$2,250**
Specialist coinsurance	**10%**
Hospital (facility) coinsurance	**10%**
Other coinsurance	**10%**

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$1,900**
In this example, Mia would pay:	
Cost Sharing	
Deductibles	$1,900
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,900**

Note: These numbers assume the patient does not participate in the plan's wellness program. If you participate in the plan's wellness program, you may be able to reduce your costs. For more information about the wellness program, please contact: 1-888-982-3862.

The plan would be responsible for the other costs of these EXAMPLE covered services.

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Email: CRCoordinator@aetna.com.

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TTY: 711

Language Assistance:

For language assistance in your language call 1-888-982-3862 at no cost.

Albanian -	Për asistencë në gjuhën shqipe telefononi falas në 1-888-982-3862.
Amharic -	ለቋንቋ እገዛ በ አማርኛ በ 1-888-982-3862 በነጻ ይደውሉ
Arabic -	للمساعدة في (اللغة العربية)، الرجاء الاتصال على الرقم المجاني 1-888-982-3862
Armenian -	Լեզվի ցուցաբերած աջակցության (հայերեն) զանգի 1-888-982-3862 առանց գնով:
Bahasa Indonesia -	Untuk bantuan dalam bahasa Indonesia, silakan hubungi 1-888-982-3862 tanpa dikenakan biaya.
Bantu-Kirundi -	Niba urondera uwugufasha mu Kirundi, twakure kuri iyi nomero 1-888-982-3862 ku busa
Bengali-Bangala -	বাংলায় ভাষা সহায়তার জন্য বিনামুল্যে 1-888-982-3862-তে কল করুন।
Bisayan-Visayan -	Alang sa pag-abag sa pinulongan sa (Binisayang Sinugboanon) tawag sa 1-888-982-3862 nga walay bayad.
Burmese -	ငွေကုန်ကျခံစရာမလိုဘဲ (မြန်မာဘာသာစကား)ဖြင့် ဘာသာစကားအကူအညီရယူရန် 1-888-982-3862 ကို ခေါ်ဆိုပါ။
Catalan -	Per rebre assistència en (català), truqui al número gratuït 1-888-982-3862.
Chamorro -	Para ayuda gi fino' (Chamoru), ågang 1-888-982-3862 sin gåstu.
Cherokee -	ᎾᏍᎩᎾ ᏕᏛᏂᎯᏍᏗ ᏗᏂᏍᏚᏢᏍᏛ ᎾᏛᎢ (ᏣᎳᎩ) ᏫᏓᎳᏫᎢᏕ 1-888-982-3862 ᏅᎾᎢ Ꮭ ᎪᎱᏍᏗ ᏧᎬᏩᏢᏗ ᏂᎨᏒᎾ.
Chinese -	欲取得繁體中文語言協助，請撥打1-888-982-3862，無需付費。
Choctaw -	(Chahta) anumpa ya apela a chi I paya hinla 1-888-982-3862.
Cushite -	Gargaarsa afaan Oromiffa hiikuu argachuuf lakkokkofsa bilbilaa 1-888-982-3862 irratti bilisaan bilbilaa.
Dutch -	Bel voor tolk- en vertaaldiensten in het Nederlands gratis naar 1-888-982-3862.
French -	Pour une assistance linguistique en français appeler le 1-888-982-3862 sans frais.
French Creole -	Pou jwenn asistans nan lang Kreyòl Ayisyen, rele nimewo 1-888-982-3862 gratis.
German -	Benötigen Sie Hilfe oder Informationen in deutscher Sprache? Rufen Sie uns kostenlos unter der Nummer 1-888-982-3862 an.
Greek -	Για γλωσσική βοήθεια στα Ελληνικά καλέστε το 1-888-982-3862 χωρίς χρέωση.
Gujarati -	ગુજરાતીમાં ભાષામાં સહાય માટે કોઈ પણ ખર્ચ વગર 1-888-982-3862 પર કૉલ કરો.

Hawaiian -	No ke kōkua ma ka ʻōlelo Hawaiʻi, e kahea aku i ka helu kelepona 1-888-982-3862. Kāki ʻole ʻia kēia kōkua nei.
Hindi -	हिन्दी में भाषा सहायता के लिए, 1-888-982-3862 पर मुफ्त कॉल करें।
Hmong -	Yog xav tau kev pab txhais lus Hmoob hu dawb tau rau 1-888-982-3862.
Ibo -	Maka enyemaka asụsụ na Igbo kpọọ 1-888-982-3862 na akwụghị ụgwọ ọ bụla
Ilocano -	Para iti tulong ti pagsasao iti pagsasao tawagan ti 1-888-982-3862 nga awan ti bayadanyo.
Italian -	Per ricevere assistenza linguistica in italiano, può chiamare gratuitamente 1-888-982-3862.
Japanese -	日本語で援助をご希望の方は、1-888-982-3862 まで無料でお電話ください。
Karen -	လာတၢ်မၤစၢၤတၢ်ကတိၤကျိာ်အဂီၤ် ကျိာ် ကိး 1-888-982-3862 လာတအိဉ်ဒီးတၢ်လၢာ်ဘျာ်လၢာ်စုဘဉ်
Korean -	한국어로 언어 지원을 받고 싶으시면 무료 통화번호인 1-888-982-3862번으로 전화해 주십시오.
Kru-Bassa -	Bɛ´m`ké gbo-kpá-kpá dyé pídyi ɖé Bǎsɔ́ɔ̀-wùɖùǔ̃n wɛ̃ɛ, ɖá 1-888-982-3862
Kurdish -	برای راهنمایی به زبان فارسی با شماره 1-888-982-3862 به خۆرایی پەیوەندی بکەن.
Laotian -	ຖ້າທ່ານຕ້ອງການຄວາມຊ່ວຍເຫຼືອໃນການແປພາສາລາວ, ກະລຸນາໂທຫາ 1-888-982-3862 ໂດຍບໍ່ເສຍຄ່າໂທ.
Marathi -	तीलभाषा (मराठी) सहाय्यासाठी 1-888-982-3862 क्रमांकावरकोणत्याहीखर्चाशिवायकॉलकरा.
Marshallese -	Ñan bōk jipañ ilo Kajin Majol, kallok 1-888-982-3862 ilo ejjelok wōnān.
Micronesian-Pohnpeyan -	Ohng palien sawas en soun kawewe ni omw lokaia Ponape koahl 1-888-982-3862 ni sohte isais.
Mon-Khmer, Cambodian -	សម្រាប់ជំនួយភាសាជា ភាសាខ្មែរ សូមទូរស័ព្ទទៅកាន់លេខ 1-888-982-3862 ដោយឥតគិតថ្លៃ។
Navajo -	T'áá shi shizaad k'ehjí bee shíká a'doowol nínízingo Diné k'ehjí koji' t'áá jíík'e hólne' 1-888-982-3862
Nepali -	(नेपाली) मा निःशुल्क भाषा सहायता पाउनका लागि 1- 888-982-3862 मा फोन गर्नुहोस् ।
Nilotic-Dinka -	Tën kuɔɔny ë thok ë Thuɔŋjäŋ cɔl 1-888-982-3862 kecïn aɣöc.
Norwegian -	For språkassistanse på norsk, ring 1-888-982-3862 kostnadsfritt.
Panjabi -	ਪੰਜਾਬੀ ਵਿੱਚ ਭਾਸ਼ਾਈ ਸਹਾਇਤਾ ਲਈ, 1-888-982-3862 'ਤੇ ਮੁਫ਼ਤ ਕਾਲ ਕਰੋ।
Pennsylvania Dutch -	Fer Helfe in Deitsch, ruf: 1-888-982-3862 aa. Es Aaruf koschtet nix.
Persian -	برای راهنمایی به زبان فارسی با شماره 1-888-982-3862 بدون هیچ هزینه ای تماس بگیرید. انگلیسی
Polish -	Aby uzyskać pomoc w języku polskim, zadzwoń bezpłatnie pod numer 1-888-982-3862.

Portuguese -	Para obter assistência linguística em português ligue para o 1-888-982-3862 gratuitamente.
Romanian -	Pentru asistenţă lingvistică în româneşte telefonaţi la numărul gratuit 1-888-982-3862
Russian -	Чтобы получить помощь русскоязычного переводчика, позвоните по бесплатному номеру 1-888-982-3862.
Samoan -	Mo fesoasoani tau gagana I le Gagana Samoa vala'au le 1-888-982-3862 e aunoa ma se totogi.
Serbo-Croatian -	Za jezičnu pomoć na hrvatskom jeziku pozovite besplatan broj 1-888-982-3862.
Spanish -	Para obtener asistencia lingüística en español, llame sin cargo al 1-888-982-3862.
Sudanic-Fulfude -	Fii yo on heɓu balal e ko yowitii e haala Pular noddee e oo numero ɗoo 1-888-982-3862. Njodi woo fawaaki on.
Swahili -	Ukihitaji usaidizi katika lugha ya Kiswahili piga simu kwa 1-888-982-3862 bila malipo.
Syriac -	1-888-982-3862
Tagalog -	Para sa tulong sa wika na nasa Tagalog, tawagan ang 1-888-982-3862 nang walang bayad.
Telugu -	భాషతో సాయం కొరకు ఎలాంటి ఖర్చు లేకుండా 1-888-982-3862 కు కాల్ చేయండి. (తెలుగు)
Thai -	สำหรับความช่วยเหลือทางด้านภาษาเป็น ภาษาไทย โทร 1-888-982-3862 ฟรีไม่มีค่าใช้จ่าย
Tongan -	Kapau ‘oku fiema'u hā tokoni ‘i he lea faka-Tonga telefoni 1-888-982-3862 ‘o ‘ikai hā ōtōngi.
Trukese -	Ren áninnisin chiakú ren (Kapasen Chuuk) kopwe kékkééri 1-888-982-3862 nge esapw kamé ngonuk.
Turkish -	(Dil) çağrısı dil yardım için. Hiçbir ücret ödemeden 1-888-982-3862.
Ukrainian -	Щоб отримати допомогу перекладача української мови, зателефонуйте за безкоштовним номером 1-888-982-3862.
Urdu -	1-888-982-3862
Vietnamese -	Để được hỗ trợ ngôn ngữ bằng (ngôn ngữ), hãy gọi miễn phí đến số 1-888-982-3862.
Yiddish -	פאר שפראך הילף אין אידיש רופט 1-888-982-3862 פריי פון אפצאל.
Yoruba -	Fún ìrànlọwọ nípa èdè (Yorùbá) pe 1-888-982-3862 lái san owó kankan rárá.