



Your Benefits – Your Choice

2019 Employee Benefits Guide



Medicare D Coverage Disclosure is Located on Page 16.

Welcome to your 2019 Benefits



Dear Employees: At Illinois Central College, we understand that your life extends beyond the workplace. That is why we offer a variety of benefit plans to help you and your family. We provide health and financial security options so you can focus on being the best at what you do and enjoy your life.

Within this guide you will find the highlights of each of the benefits including medical, dental, vision insurance and more! These benefits are yours to choose and if elected will be paid for through convenient payroll deductions as long as you are a benefit-eligible employee of Illinois Central College.

We encourage you to read through this guide, share it with your family members, and ask us any questions that you have so that you are educated and empowered to choose the benefits that are best for you.

If you are a New Employee: This is your chance to elect benefits and enroll yourself and your eligible dependents. Benefits become effective the first day of employment. If you take no action within the first seven days of employment, you will have no benefits and you will not have another chance - unless you experience a qualifying life event. Make sure to return your enrollment forms before the deadline to ensure you have coverage!

We look forward to a great year!

Sincerely,
Illinois Central College Benefits Department

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The information described within this guide is only intended to be a summary of your benefits. It does not describe or include all benefit provisions, limitations, exclusions, or qualifications for coverage. Please review your Summary Plan Description for a complete explanation of your benefits. If the benefits described herein conflict in any way with the Summary Plan Description, the Summary Plan Description will prevail. You can obtain a copy of the Summary Plan Description from the Benefits Department.

BENEFIT CONTACT INFORMATION

Coverages	Carrier	Contact
Medical Plans	Administered by Consociate	Customer Service: 309-694-5002 Website: www.consociate.com
Physician Network	First Choice Methodist Network	Customer Service: 866-510-2922 Website: www.unitypoint.org/Peoria
Pre-Certification	Hines & Associates	Customer Service: 1-800-944-9401 Website: www.precertcare.com Dialysis Services: 877-218-4955 Out of Area Participation Referrals: 800-678-7427 Or visit www.multiplan.com
Pharmacy Plan	Express Scripts	Member Contact: 1-855-315-4272 Pharmacy Contact: 1-800-922-1557 Website: express-scripts.com
Dental Plan	Consociate	Customer Service: 309-694-5002 Website: www.consociate.com
Vision Plan		
Life & AD&D Plans	Symetra	See Illinois Central College Benefits Department
Accident, Cancer, Hospital Indemnity Plans	AFLAC	Representative: Roy Trimble Phone: (309) 697-2200
Flexible Spending Accounts	Consociate	Customer Service: 309-694-5002 Website: www.consociate.com
Employee Assistance Program	Chestnut Global Partners	Customer Service: 1-800-433-7916 Website: chestnut.personaladvantage.com

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ELIGIBILITY, ENROLLMENT & CHANGES



Employee Eligibility:

All full-time employees who work for Illinois Central College at least 30 hours per week on a regular basis are eligible for benefits through Illinois Central College effective the first day of employment.

Your Eligible Dependents:

- Your legally married spouse who resides in the United States.
- Children under the age of 26 (including: natural born, adopted or placed with you for adoption, stepchildren, children who meet the requirements of the Coverage Pursuant to a Qualified Medical Child Support Order.

Benefit election changes during the year may be made for the following reasons:

- Changes in the Employee's legal marital status such as marriage, divorce, separation, or the death of a spouse.
- A change in the number of dependents such as birth, death, or adoption.
- Changes in employment status of the employee or of the employee's spouse or dependents. This includes the beginning or ending of employment, new or different work hours, change from full-time to part-time status or vice versa, the beginning or end of an unpaid leave of absence.
- A dependent becomes eligible or ceases to be eligible for coverage due to age.
- Employee, spouse or dependent becoming, or ceasing to be, eligible for Medicare or Medicaid.
- A judgment, decree, or order that results from a divorce or legal separation.
- **An election change must be made within 30 days of the qualifying event.**

Pretax Elections:

Employee premiums will be deducted on a pre-tax basis through payroll deduction unless requested by the employee. Due to IRS rules, contributions cannot be revoked or changed during the plan year, unless you experience a qualifying "Status Change" as described above.

HOW MY MEDICAL PLAN WORKS

Preferred Provider Option (PPO) Plan

A PPO Network is all about choice. You get to choose which providers to visit each time you need care and you can help control your own medical costs by choosing providers from within the PPO. When you go out-of-network, you can visit any doctor you want, but you pay a greater portion of the cost. **Please Note: In the Peoria area, you must use Unity Point Methodist/ Proctor for your hospital/diagnostic needs. If you use out of network hospitals/diagnositcs in Peoria, the benefits paid by the plan will be reduced by 50%.**

In-Network Benefits

- When you visit a provider that is within the PPO network, you will maximize the benefits of your medical plan. You do not have to select a Primary Care Physician, nor do you need a referral to see a specialist. Simply visit any doctor you choose within the PPO network for whatever care you need.
- Even within the PPO Network, you are responsible for the annual deductible before your plan begins paying coinsurance for most benefits. After your deductible is met, you are only responsible for your portion up to your annual out-of-pocket maximum.

Out-of-Network Benefits

- Your plan allows you to visit any provider you want, even if they are not within the PPO network. However, you may have to pay more for the services of any provider who is out-of-network.
- When you go out-of-network, your out-of-network penalties **do not count towards the plan's annual out of pocket maximum.**
- When you visit an out-of-network provider, the plan bases its payments on what it considers the usual, customary, and reasonable rate (UCR) for each service provided. If the charge incurred is more than the UCR limit set forth by the plan, you are responsible for paying the full difference between the charge and what the plan pays.
- When you receive out-of-network care, benefits are subject to a 50% reduction for which the plan member (you) are responsible. Plus, you will still need to contact Hines & Associates to pre-certify hospital stays.

Pre-Certification Process

The plan requires pre-certification prior to inpatient admissions by calling the pre-certification number listed on the benefit contacts page. The plan also requires pre-certification prior to obtaining services for dialysis treatment.

Terms to Know

- **In-Network:** The doctors and hospitals that participate in the plan by accepting negotiated discounts to their fees.
- **Co-Pay:** A flat dollar amount that you are required to pay at the time of service for Medical or Rx Drugs. Not all Health Plans use copays.
- **Out-of-Pocket Maximum:** The maximum amount that you could be responsible for paying in any plan year - excluding your deductible, copays, and out-of-network penalties and charges above UCR - before the health plan covers 100% of remaining eligible expenses.
- **Deductible:** Your initial portion of Healthcare costs that you will pay before your plan begins cost-sharing.
- **Coinsurance:** The percentage of the cost the plan will pay after you meet your deductible.
- **Usual, Customary, & Reasonable (UCR):** The most a plan will consider eligible for a covered expense. UCR charges are based on the range of fees charged by providers with comparable training for the same or similar services in your area. When you receive care in-network, UCR allowance limitations do not apply

MEDICAL PLAN SUMMARY

Illinois Central College offers all eligible employees access to a PPO medical plan. You may see any provider you choose but will receive the highest level of benefits when you stay In-Network. See below for a summary of the benefits provided by the medical plan. See page 8, for information on additional medical plans offered that can provide greater total coverage for active employees and their dependents.

Medical Plan Summary	In-Network	Out-of-Network
Deductible		
Individual	\$325	\$325
Single + 1	\$650	\$650
Family	\$650	\$650
Coinsurance (You Pay)	You Pay 10% after Deductible	You Pay 10% after Deductible
Out-of-Pocket Max		\$1,500*
Individual		\$3,000*
Single +1		\$3,000*
Family		
	<i>*Out-of-Network charges above "usual, customary, & reasonable" (as defined by the plan) do not track towards out of pocket maximum.</i>	
Preventative Care	100% covered, deductible waived	Physician's Office Services: 10% after Deductible All Other Services: 50% after Deductible
Office Visits	10% after Deductible	10% after Deductible
Urgent Care	10% after Deductible	10% after Deductible
Hospitalization		
Facility Fee	10% after Deductible	50% after Deductible
Physician/Surgeon Fee	10% after Deductible	50% after Deductible
Emergency Room	\$250 copay then 0% after Deductible Copay waived if admitted	

Prescription Drugs (30-Day Retail)	In-Network	Out-of-Network
Generic	\$12 Copay	Not Covered
Brand – Single Source	\$25 Copay	
Brand – Multi Source (No Sub)	\$25 Copay	
Brand – Multi Source	\$55 Copay	
Specialty Drug	\$150 Copay	

Monthly Employee Cost	PPO, Maxi, Max II	MRP, Supplemental
Employee Only	\$66	\$33
Employee + 1	\$132	\$66
Family	\$165	\$82.50

PHARMACY BENEFIT DETAILS

Please review this page for important details about the Prescription Drug/Pharmacy benefit that is part of the ICC medical plan. The Prescription Drug Program does not cover drugs not approved by the FDA, experimental drugs, fertility drugs, drugs for sexual dysfunction, dietary drugs or drugs for weight reduction, hair loss, growth hormones, injectable medications (except insulin) and/or specialty drugs unless pre-authorized by the Plan, drugs prescribed primarily for cosmetic purposes, or drugs which may be dispensed without a prescription.

Save on Generics by using the in-house chain pharmacy programs, rather than your Express Scripts drug card, where you can receive a 90 day supply of over 400 generic drugs for less than normal copay.

	In-Network Retail Pharmacy - 30 Day	Mail Order - 90 Day	Out-of-Network Retail Pharmacy
Generic Drugs	\$12 Copay	\$15 Copay	Not Covered
Brand - Single Source	\$25 Copay	\$27 Copay	Not Covered
Brand - Multi Source (No Sub)	\$25 Copay	\$27 Copay	Not Covered
Brand - Multi Source	\$55 Copay	\$54 Copay	Not Covered
Specialty Drugs	\$150 Copay	\$150 Copay	Not Covered

Maximum Supplies Allowed: 30 day supply at retail pharmacy, 90 day supply mail order through Express Scripts. No refills on retail until 23 days have passed. No refills on mail order until 76 days have passed.

Express Scripts Pharmacy Network:

- National Network
- Pharmacies in-network include: Walgreens, CVS, Walmart, Rite Aid, Kroger, and many more

Advanced Utilization Management

- **Prior Authorization (PA):** Ensures the clinically appropriate use of medications & safety of the patient.
- An example of when a PA would be used is the use of a Hepatitis C drug. If Harvoni was prescribed but Viekira is the preferred formulary product, the physician would be consulted to see if Viekira could be substituted. If the provider agrees then a new script would be submitted. In determining to authorize coverage for such a drug under the PA program, ESI will rely entirely upon information about the member and the diagnosis for the member's condition provided to it from the provider. ESI will not undertake to determine medical necessity, make diagnosis or substitute ESI's judgment for the professional judgment and responsibility of the provider.
- **Step Therapy:** Encourages members to try clinically effective, front-line medications (usually generics) before trying second-line (usually brand name) medications. If for example your provider prescribes Lipitor, atorvastatin (its generic version) would be tried first. If it didn't work or had side effects the backup brand could be tried.
- **Drug Quantity Management:** Aligns the dispensed quantity of prescription medication with FDA-approved dosage guidelines. As in the example above for atorvastatin, instead of filling the prescription for the full 30 days it may initially be filled for only 15 days to ensure that if there are side effects there would be less wasted medication.



ADDITIONAL MEDICAL PLAN OPTIONS

The College offers three additional medical plans that can provide supplemental coverage for active employees and their dependents who have other primary insurance. Individuals covered by another health care plan may elect these optional plans rather than the regular Medical Benefits. If other coverage is lost, you may immediately change to regular Medical Benefits at the current contribution rate. An individual may not be covered under both regular Medical Benefits and option 2, 3, or 4. Except for the Maxi Plan, you may not be covered under a different option than your dependents without approval of the Plan Sponsor. Reasonable and customary determinations apply to each option. If the contractual benefits of your other health care plan, when combined with the Supplemental Plans, are ever less than total benefits that would have been received under regular Medical Benefits, the Supplemental Plans will pay the difference as a No Loss benefit. For more details, contact the Benefits Office.

2. Supplemental Plan: The Supplemental Plan pays 100% (no deductible) for physician office visits related to an illness or injury, routine exams and related tests, immunizations, vaccinations, and allergy injections and the co-pays not paid by your spouse's drug plan. If you do not have a drug card through your spouse, you will continue to have the ICC drug card, but the co-pays in this case will not be reimbursed.

3. Maxi Plan: The Maxi Plan covers the same scope of benefits as the regular Medical Benefits. Benefits are 100%, no deductible, except that the maximum paid on an inpatient hospital bill is \$1,500 per admission. In addition, the Maxi Plan pays routine exams and related tests and immunizations and vaccinations in full as well as the co-pays under the ICC drug plan. An individual may change from the Maxi Plan to the Comprehensive Medical Benefits at any time. The Maxi Plan is available to anyone who has Medicare that is secondary to this Plan.

4. Maxi Plan II: The Maxi II option is the same as the Maxi Plan, except Maxi II does not cover hospital billed charges, oncology services, or prescription drugs, except for preventative care, emergency care, or clinical trial expenses other than for the trial drug. An individual may change to the Maxi II from other medical coverage in the Plan, or vice-versa, at any time.

5. Medical Reimbursement Plan (MRP): Employees covered under Tri-Care or another employer sponsored medical plan may increase overall benefits with the MRP. The MRP turns services covered under your other health plan into a 100% benefit plan. The MRP reimburses you in full for your other plan's deductibles, co-insurance and co-pays (except your other plan's non-PPO hospital charges unless an exception is made by this Plan). If routine exams or office visits are not covered at all under your other health plan under any circumstances, these services will be reimbursed by the MRP at reasonable and customary allowances. Benefits are paid directly to you when you send a copy of your other plan's explanation of benefits, or a copy of your prescription receipts showing your drug co-pays, to Consociate. Write the health care provider's name and phone number on the explanation of benefits.

DENTAL PLAN SUMMARY



Employees, spouses, and dependents enrolled in the Illinois Central College Medical plan also receive dental coverage at no additional cost. This benefit saves you money on routine exams and cleanings as well as restorative services. The Plan will pay reasonable and customary fees of licensed dentists up to a maximum of \$1,200 per calendar year per person on the following basis.

Payable at 80%:

- *Oral exams, prophylaxis (cleaning and polishing), and bitewing x-rays twice per calendar year (January 1 – December 31)*
- *Full mouth x-rays once in any consecutive 24-month period.*
- *Emergency treatment.*
- *Topical fluoride applications (to age 19)*
- *Endodontics, including pulpotomy, pulp capping and root canal therapy.*
- *Denture repair and relining, and re-cementing of inlays, on-lays and crowns.*
- *Extractions, dental tests, oral surgery and related anesthesia.*
- *Fillings consisting of amalgam, silicate and plastic restorations, and sealants.*
- *Space maintainers.*
- *Periodontics (diseases of the gum) and apicoectomy*

Payable at 50%

- *Gold foil restorations, inlays and on-lays, and crowns and crown buildup.*
- *Dentures, full and partial.*
- *Bridges, fixed and removable.*
- *Orthodontics (to age 19).*
- *Mandibular advancement and tongue restraining devices (for sleep apnea).*

The date you take possession of a dental appliance will be the date the expense is incurred. The Plan will not pay for lost or misplaced dentures, cosmetic dentistry, implants or bridges involving dental implants; the placement of crowns, inlays and on-lays, bridges and dentures or the relining of dentures more than once per consecutive five-year period for the same tooth or teeth; general anesthesia for three or less simple extractions; hospital charges for out-patient surgery for the removal of impacted teeth, unless pre-approved by the Claim Administrator, or charges of a dentist except as set forth above.

VISION PLAN SUMMARY



Employees, spouses, and dependents enrolled in the Illinois Central College Medical plan also receive vision coverage at no additional cost. You may visit any eye doctor that you choose because there is no “network.” The Plan will pay reasonable and customary fees of licensed vision care providers on the following basis.

Examinations

- 80% of reasonable and customary charges for one exam per individual in any calendar year.
- Calendar Year: January 1 – December 31

Frames, Lenses, & Contact Lenses (*Member chooses Frames + Lenses or Contacts – not both*):

- \$125 maximum per individual once in any calendar year.
- Calendar Year: January 1 – December 31

Please Note: Dates for examination and for dispensing frames and lenses may differ. Benefits are once per calendar year. The date you take possession of frames, lenses or contact lenses will be the date the expense is incurred.

LIFE/AD&D PLAN SUMMARY



All active full-time employees regularly working over 30 hours per week will be enrolled in the Illinois Central College Group Life and AD&D Insurance plan through **Symetra** Life Insurance Company. This coverage is provided by Illinois Central College at no cost to you. For all full-time employees, your Company-Paid Life and AD&D benefit is as follows:

Basic Employee Life (Paid by ICC)

- 2x your annual earnings, up to \$500,000 maximum.
- Guaranteed Issue Amount: \$400,000
- If 2x your annual earnings exceeds \$400,000 and you would like to reach the \$500,000 benefit maximum you need to complete the Evidence of Insurability form and answer the medical questions to get approved.

Basic Employee AD&D (Paid by ICC)

- 2x your annual earnings, up to \$500,000 maximum (the amount matches your Life coverage amount).
- This benefit pays if death is caused by an accident or if you survive and accident with certain catastrophic injuries such as loss of limb or eye.

Voluntary Life/AD&D Plan Summary: Illinois Central College wants you to be covered and your family to be protected, which is why we are offering all full-time eligible employees the opportunity to enroll in Voluntary Life and Accidental Death & Dismemberment coverage through **Symetra**. Your designated beneficiary will receive a benefit to help ease their financial burden if you die. Accidental Death and Dismemberment (AD&D) provides an additional benefit if you die or become dismembered due to an accident.

Supplemental Employee Life (Paid by the employee)

- Elect an additional one-time your annual earnings, up to a maximum of \$250,000
- Guarantee Issue Amount: \$200,000*
- If one-time your annual earnings is above \$200,000 and you would like to elect over that amount, you will need to complete the evidence of insurability form and answer the medical questions to get approved.

Optional AD&D (Paid by the employee)

- Additional AD&D coverage is available only at the time of employment. Various options are available. Please speak to the benefits department.

If you do not update your beneficiaries it will make it harder for the right person to receive your benefit, if ever needed. Please update your beneficiaries periodically!

***Important Note: Guaranteed Issue is only available upon your initial employment. If you don't take advantage of this insurance within 30 days of being hired, you will be subject to medical questions to enroll at a later date.**

ADDITIONAL VOLUNTARY BENEFITS



Aflac Voluntary Benefits: Illinois Central College has partnered with **Aflac** to bring you access to reduced-rate, payroll deducted benefits. You have the choice of the plans below and each plan pays money directly to you when you incur a covered condition. To enroll in any of these plans or to get more information, please contact Benefits. You may also contact our Aflac representative Roy Trimble at (309) 697-2200.

- **Accident Insurance:** Take advantage of Aflac's accident insurance policy to maintain peace of mind and help pay for emergency treatment, as well as for treatment-related transportation and lodging.
- **Cancer Insurance:** Aflac cancer insurance is here to help you and your family better cope financially and emotionally if a positive diagnosis of cancer ever occurs.
- **Hospital Indemnity Insurance:** A trip to the hospital can be a little intimidating. And while we can't take all the uncertainty out of your stay, Aflac can help you make some of those unexpected costs a bit more manageable.
- **Critical Care Protection:** Provides peace of mind if you experience a serious health event such as a heart attack or stroke.

Consociate Voluntary Benefits: Illinois Central College offers you two different FSA options through **Consociate:** a Medical Reimbursement Account and a Dependent Care Reimbursement Account. By using these accounts, you can save money and bring home more of your income by paying for medical care and dependent care expenses using PRE-TAX dollars from your payroll. To enroll and/ or to get more information on flexible spending accounts, please contact the Benefits Department at (309) 694-5398.

State Universities Retirement System: As an employee of ICC, your primary long term disability insurance will be administered through SURS. Please speak to the Human Resources department for more details. Additional disability coverage, available through The Hartford, is described below.

The Hartford Benefits: Illinois Central College believes in the importance of protecting your income and is happy to partner with **The Hartford** to offer Long-Term Disability coverage. Long-Term Disability insurance is intended to replace a portion of your income when you are deemed disabled and unable to work due to a non-work-related injury or illness. Please refer to your employee handbook for information on our policy regarding paid sick days, which are to be used for illness or injuries that prevent you from working before you have met the elimination period for Long Term Disability coverage. To get more information on Long-Term Disability Insurance, please contact the Benefits Department at (309) 694-5398.

EMPLOYEE ASSISTANCE PROGRAM



No one is immune to personal concerns, and when left unaddressed, they can impact your work performance or emotional well-being. The Employee Assistance Program (EAP) is designed to help you resolve personal concerns before they become more serious and difficult to manage. You and your dependent family members can receive short term, professional counseling to address a wide variety of concerns. The EAP also provides access to information and resources that can help you answer virtually any personal question or concern.

Counseling Services: The EAP provides employees and their dependents up to three free counseling sessions per problem, per year, or you may be referred to a professional resource that has expertise within your area of concern.

Some of the concerns the EAP can help with include:

- Stress Management
- Work Concerns
- Conflict Resolution
- Parenting Support
- Marital and Relationships Anxiety and Depression
- Substance Abuse
- Work-Life Balance
- Domestic Violence
- Grief and Loss

Nutrition & Exercise: The EAP offers an annual, one-time consultation with a registered dietitian and health fitness specialist. Nutrition and exercise questions or topics may include, but are not limited to:

- **Nutrition** – Portion Control, Weight Loss, & Nutrient Intake
- **Exercise** – Planning and Preparation, & Proper Form and Safety

Work/Life Services: Call the EAP toll-free number or visit the website for additional services including:

- **Legal Consultation** – Family Law, Will and Estate Planning, Mediation Services, & Power of Attorney
- **Financial Consultation** – Budgeting, Debt Management, Improving Your Credit, & Taxes
- **Identity Theft** – Full Restoration Services
- **Elder Care** – In-Home Assessment, & Community Resource Referrals

For more information:

- **Visit:** chestnut.personaladvantage.com (User name: icc)
- **Call:** (800) 433-7916

ANNUAL REQUIRED NOTICES

Illinois Central College Annual Health Law Notice Disclosures

Michelle's Law Notice

If there is a medically necessary leave of absence from a post-secondary educational institution or other change in enrollment that: (1) begins while a dependent child is suffering from a serious illness or injury; (2) is certified by a physician as being medically necessary; and (3) causes the dependent child to lose student status for purposes of coverage under the plan, that child may maintain dependent eligibility for up to one year. If the treating physician does not provide written documentation when requested by the Plan Administrator that the serious illness or injury has continued, making the leave of absence medically necessary, the plan will no longer provide continued coverage.

Benefits During Family Medical Leave

Assuming the Plan Administrator meets certain criteria during the preceding calendar year, the Plan will comply with the Family and Medical Leave Act (FMLA) of 1993 as amended, which provides benefit continuation rights during an approved medical leave of absence. If the Plan Administrator is subject to the law, an employee and any dependents covered under a health benefit plan may be eligible to continue the coverage under that plan for a certain period of time.

Any employer contributions made under the terms of the Plan shall continue to be made on behalf of such employee electing to maintain coverage while on FMLA leave. An employee on FMLA leave must make any applicable contributions to maintain coverage. To the extent required under the FMLA and in accordance with procedures established by the Plan Administrator such employee contributions may be payable:

- prior to the employee taking the leave; or
- during the leave; or
- repaid to the employer through payroll deductions upon return to work following the leave.

Contact the Plan Administrator for additional information on the FMLA leave policy or to request leave. Certain rights under specific state family leave laws may also apply.

Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA)

Under USERRA, an employer is required to offer COBRA-like continuation of coverage to covered employees in the uniformed services if their absence from work during military duty would result in a loss of coverage as a result of such active duty. The maximum length of USERRA continuation of coverage is the lesser of 24 months beginning on the date of the employee's departure, or the period beginning on the date of the employee's departure and ending on the date on which the employee failed to return from active duty or apply for reemployment within the time allowed by USERRA. If an employee elects to continue coverage pursuant to USERRA, such

employee, and any covered dependents, will be required to pay up to 102% of the full premium for coverage elected. For military leaves of 30 days or less, the employee is not required to contribute more than the amount he or she would have paid as an active employee. Continued coverage under this provision pursuant to USERRA will reduce any coverage continuation provided under COBRA Continuation.

Premium Assistance Under Medicaid and The Children's Health Insurance Program (CHIP) – Applies to Group Health Plans Only

If an Employee or the Employee's child(ren) are eligible for Medicaid or CHIP and are eligible for health coverage from an employer, the state may have a premium assistance program that can help pay for coverage, using funds from State Medicaid or CHIP programs. If the Employee or his/her child(ren) aren't eligible for Medicaid or CHIP, they won't be eligible for these premium assistance programs but may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit www.healthcare.gov.

If the Employee or his/her dependents are already enrolled in Medicaid or CHIP and live in a State listed below, they may contact the State Medicaid or CHIP office to find out if premium assistance is available.

If the Employee or his/her dependents are NOT currently enrolled in Medicaid or CHIP, and they think they might be eligible for either of these programs, they can contact their State Medicaid or CHIP office or dial **1-877-KIDS NOW** or www.insurekidsnow.gov to find out how to apply. If they qualify, ask if the state has a program that might help pay the premiums for an employer-sponsored plan.

If the Employee or his/her dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under their employer's plan, the employer must allow the Employee to enroll in the employer plan if not already enrolled. This is called a "special enrollment" opportunity, and **the Employee must request coverage within 60 days of being determined eligible for premium assistance**. If the Employee has questions about enrolling in their employer's 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 January 31, 2018. Contact your State for more information on eligibility –

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

ALASKA – 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>

ARKANSAS – Medicaid
Website: <http://myarhipp.com/>
Phone: 1-855-MyARHIPP (855-692-7447)
COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)
Health First Colorado Website:
<https://www.healthfirstcolorado.com/>
Health First Colorado Member Contact Center:
1-800-221-3943/ State Relay 711
CHP+: Colorado.gov/HCPF/Child-Health-Plan-Plus
CHP+ Customer Service: 1-800-359-1991/
State Relay 711

FLORIDA – Medicaid
Website: <http://flmedicaidprecovery.com/hipp/>
Phone: 1-877-357-3268

GEORGIA – Medicaid
Website: <http://dch.georgia.gov/medicaid>
- Click on Health Insurance Premium Payment (HIPP)
Phone: 404-656-4507

INDIANA – Medicaid
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

IOWA – Medicaid
Website:
<http://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp>
Phone: 1-888-346-9562

KANSAS – Medicaid
Website: <http://www.kdheks.gov/hcf/>
Phone: 1-785-296-3512

KENTUCKY – Medicaid
Website: <http://chfs.ky.gov/dms/default.htm>
Phone: 1-800-635-2570

LOUISIANA – Medicaid
Website:
<http://dhh.louisiana.gov/index.cfm/subhome/1/n/331>
Phone: 1-888-695-2447

MAINE – Medicaid
Website: <http://www.maine.gov/dhhs/ofi/public-assistance/index.html>
Phone: 1-800-442-6003
TTY: Maine relay 711

MASSACHUSETTS – Medicaid and CHIP
Website:
<http://www.mass.gov/eohhs/gov/departments/masshealth/>
Phone: 1-800-862-4840

MINNESOTA – Medicaid

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

MISSOURI – Medicaid

Website: <https://www.dss.mo.gov/mhd/participants/pages/hipp.htm>
Phone: 573-751-2005

MONTANA – Medicaid

Website: <http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP>
Phone: 1-800-694-3084

NEBRASKA – Medicaid

Website: <http://www.ACCESSNebraska.ne.gov>
Phone: (855) 632-7633
Lincoln: (402) 473-7000
Omaha: (402) 595-1178

NEVADA – Medicaid

Medicaid Website: <https://dhcfp.nv.gov>
Medicaid Phone: 1-800-992-0900

NEW HAMPSHIRE – Medicaid

Website: <https://www.dhhs.nh.gov/ombp/nhhpp/>
Phone: 603-271-5218
Hotline: NH Medicaid Service Center at 1-888-901-4999

NEW JERSEY – Medicaid and CHIP

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

NEW YORK – Medicaid

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

NORTH CAROLINA – Medicaid

Website: <https://dma.ncdhhs.gov/>
Phone: 919-855-4100

NORTH DAKOTA – Medicaid

Website: <http://www.nd.gov/dhs/services/medicalserv/medicaid/>
Phone: 1-844-854-4825

OKLAHOMA – Medicaid and CHIP

Website: <http://www.insureoklahoma.org>
Phone: 1-888-365-3742

OREGON – Medicaid

Website: <http://healthcare.oregon.gov/Pages/index.aspx>
<http://www.oregonhealthcare.gov/index-es.html>
Phone: 1-800-699-9075

PENNSYLVANIA – Medicaid

Website: <http://www.dhs.pa.gov/provider/medicalassistance/healthinsurancepremiumpaymenthippprogram/index.htm>

Phone: 1-800-692-7462

RHODE ISLAND – Medicaid

Website: <http://www.eohhs.ri.gov/>
Phone: 855-697-4347

SOUTH CAROLINA – Medicaid

Website: <https://www.scdhhs.gov>
Phone: 1-888-549-0820

SOUTH DAKOTA - Medicaid

Website: <http://dss.sd.gov>
Phone: 1-888-828-0059

TEXAS – Medicaid

Website: <http://gethipptexas.com/>
Phone: 1-800-440-0493

UTAH – Medicaid and CHIP

Medicaid Website: <https://medicaid.utah.gov/>
CHIP Website: <http://health.utah.gov/chip>
Phone: 1-877-543-7669

VERMONT– Medicaid

Website: <http://www.greenmountaincare.org/>
Phone: 1-800-250-8427

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

WASHINGTON – Medicaid

Website: <http://www.hca.wa.gov/free-or-low-cost-health-care/program-administration/premium-payment-program>
Phone: 1-800-562-3022 ext. 15473

WEST VIRGINIA – Medicaid

Website: <http://mywvhipp.com/>
Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)

WISCONSIN – Medicaid and CHIP

Website: <https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf>
Phone: 1-800-362-3002

WYOMING – Medicaid

Website: <https://wyequalitycare.acs-inc.com/>
Phone: 307-777-7531

To see if any other states have added a premium assistance program since January 31, 2018, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

Important Disclosures**Women’s Health and Cancer Rights Act of 1998**

The Federal Women’s Health and Cancer Rights Act of 1998 requires coverage of treatment related to mastectomy. If the participant is eligible for mastectomy benefits under health coverage and elects breast reconstruction in connection with such mastectomy, she is also covered for the following:

- Reconstruction of the breast on which mastectomy has been performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses;
- Treatment of physical complications of all states of mastectomy, including lymphedemas.

Coverage for reconstructive breast surgery may not be denied or reduced on the ground that it is cosmetic in nature or that it otherwise does not meet the coverage definition of “medically necessary.” Benefits will be provided on the same basis as for any other illness or injury under the Plan. Coverage for breast reconstruction and related services will be subject to applicable deductibles, co-payments and coinsurance amounts that are consistent with those that apply to other benefits under the Plan.

Maternity Coverage Length of Hospital Stay

Group health plans and health insurance issuers offering group health insurance coverage generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a normal vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother’s or newborn’s attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 or 96 hours, as applicable. Additionally, no group health plan or issuer may require that a provider obtain authorization from the Plan or insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Medical Child Support Orders

A Component Benefit Plan must recognize certain legal documents presented to the Plan Administrator by participants or their representatives. The Plan Administrator may be presented court orders which require child support, including health benefit coverage. The Plan Sponsor must recognize a Qualified Medical Child Support Order (QMCSO), within the meaning of ERISA section 609(a)(2)(B), under any Component Benefit Plan providing health benefit coverage.

A QMCSO is a state court or administrative agency order that requires an employer’s medical plan to provide benefits to the child of an employee who is covered, or eligible for coverage, under the employer’s plan. QMCSOs usually apply to a child who is born out of wedlock or whose parents are divorced. If a QMCSO applies, the employee must pay for the child’s medical coverage and will be required to join the Plan if not already enrolled.

The Plan Administrator, when receiving a QMCSO, must promptly notify the employee and the child that the order has been received and what procedures will be used to determine if the order is "qualified." If the Plan Administrator determines the order is qualified and the employee must provide coverage for the child pursuant to the QMCSO, contributions for such coverage will be deducted from the employee's paycheck in an amount necessary to pay for such coverage. The affected employee will be notified once it is determined the order is qualified. Participants and beneficiaries can obtain a copy of the procedure governing QMCSO determinations from the Plan Administrator without charge.

New Health Insurance Marketplace Coverage Options and Your Health Coverage

PART A: General Information

When key parts of the health care law took effect in 2014, a new way to buy health insurance became available: the Health Insurance Marketplace. To assist Employees as they evaluate options for themselves and their family, this notice provides some basic information about the new Marketplace and employment-based health coverage offered by their employer.

What is the Health Insurance Marketplace?

The Marketplace is designed to help individuals and families find health insurance that meets their needs and fits their budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. Employees may also be eligible for a new kind of tax credit that lowers their monthly premium right away. The 2018 open enrollment period for health insurance coverage through the Marketplace began on Nov. 15, 2017, and ended on Feb. 15, 2018. Individuals must have enrolled or changed plans prior to Dec. 15, 2017, for coverage starting as early as Jan. 1, 2018. After Feb. 15, 2018, individuals can get coverage through the Marketplace for 2018 only if they qualify for a special enrollment period or are applying for Medicaid or the Children's Health Insurance Program (CHIP).

Can individuals Save Money on Health Insurance Premiums in the Marketplace?

Individuals may qualify to save money and lower monthly premiums, but only if their employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on premiums depends on household income.

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

Yes. If the Employee has an offer of health coverage from his/her employer that meets certain standards, they will not be eligible for a tax credit through the Marketplace and may wish to enroll in their employer's health plan. However, an individual may be eligible for a tax credit that lowers their monthly premium, or a reduction in certain cost-sharing if their employer does not offer coverage at all or does not offer coverage that meets certain standards. If the cost of a plan from an employer that would cover the Employee (and not any other members of their family) is more than 9.56% of household income for the year, or if the coverage the employer provides does not meet the "minimum value" standard set

by the Affordable Care Act, the Employee may be eligible for a tax credit. *

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

How Can Individuals Get More Information?

For more information about coverage offered by the Employer, please check the summary plan description or contact Human Resources.

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

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

HIPAA Notice of Privacy Practices

The Illinois Central College Group Medical Plan (the "Plan"), which includes medical and flexible spending account coverages offered under the Illinois Central College Plans, are required by law (under the Administrative Simplification provision of the Health Insurance Portability and Accountability Act of 1996 HIPAA's privacy rule) to take reasonable steps to ensure the privacy of your personally identifiable health information. This Notice is being provided to inform you of the policies and procedures Illinois Central College has implemented and your rights under them, as well as under HIPAA. These policies are meant to prevent any unnecessary disclosure of your health information.

Use and Disclosure of Your Health Information by the Plan that Do Not Require Your Authorization: The plan may use or disclose your health information (that is protected

health information (PHI), as defined by HIPAA's privacy rule) for:

1. Payment and Health Care

Operations: In order to make coverage determinations and payment (including, but not limited to, billing, claims management, subrogation, and plan reimbursement). For example, the Plan may provide information regarding your coverage or health care treatment to other health plans to coordinate payment of benefits. Your health information may also be used or disclosed in order for the Plan to carry out its own operations regarding the administration of the Plan and provide coverage and services to the Plan's participants. For example, the Plan may use your health information to project future benefit costs, to determine premiums, conduct or arrange for case management or medical review, for internal grievances, for auditing purposes, business planning and management activities such as planning related analysis, or to contract for stop-loss coverage. Pursuant to the Genetic Information Non-Discrimination Act (GINA), the Plan does not use or disclose genetic information for underwriting purposes.

2. Disclosure to the Plan Sponsor: As required, in order to administer benefits under the Plan. The Plan may also provide health information to the plan sponsor to allow the plan sponsor to solicit premium bids from health insurers, to modify the Plan, or to amend the Plan.

3. Requirements of Law: When required to do so by any federal, state or local law.

4. Health Oversight Activities: To a health oversight agency for activities such as audits, investigations, inspections, licensure, and other

proceedings related to the oversight of the health plan.

5. Threats to Health or Safety: As required by law, to public health authorities if the Plan, in good faith, believes the disclosure is necessary to prevent or lessen a serious or imminent threat to your health or safety or to the health and safety of the public.

6. Judicial and Administrative Proceedings: In the course of any administrative or judicial proceeding in response to an order from a court or administrative tribunal, in response to a subpoena, discovery request or other similar process. The Plan will make a good faith attempt to provide written notice to you to allow you to raise an objection.

7. Law Enforcement Purposes: To a law enforcement official for certain enforcement purposes, including, but not limited to, the purpose of identifying or locating a suspect, fugitive, material witness or missing person.

8. Coroners, Medical Examiners, or Funeral Directors: For the purpose of identifying a deceased person, determining a cause of death or other duties as authorized by law.

9. Organ or Tissue Donation: If you are an organ or tissue donor, for purposes related to that donation.

10. Specified Government Functions: For military, national security and intelligence activities, protective services, and correctional institutions and inmates.

11. Workers' Compensation: As necessary to comply with workers' compensation or other similar programs.

12. Distribution of Health-Related Benefits and Services: To provide information to you on health-related benefits and services that may be of interest to you.

Notice in Case of Breach
Illinois Central College is required maintain the privacy of your PHI; provide you with this notice of its legal duties and privacy practices with respect to PHI; and to notify you of any breach of your PHI.

Use and Disclosure of Your Health Information by the Plan that Does Require Your Authorization: Other than as listed above, the Plan will not use or disclose without your written authorization. You may revoke your authorization in writing at any time, and the Plan will no longer be able to use or disclose the health information. However, the Plan will not be able to take back any disclosures already made in accordance with the Authorization prior to its revocation. The following uses and disclosures will be made only with authorization from the individual: (i) most uses and disclosures of psychotherapy notes (if recorded by a covered entity); (ii) uses and disclosures of PHI for marketing purposes, including subsidized treatment communications; (iii) disclosures that constitute a sale of PHI; and (iv) other uses and disclosures not described in this notice.

Your Rights with Respect to Your Health Information: You have the following rights under the Plan's policies and procedures, and as required by HIPAA's privacy rule:

Right to Request Restrictions on Uses and Disclosures: You may request the Plan to restrict uses and disclosures of your health information. The Plan will accommodate reasonable requests;

however, it is not required to agree to the request, unless it is for services paid completely by you out of your own pocket. If you wish to request a restriction, please send it in writing to HIPAA Privacy Officer, at Illinois Central College, 1 College Dr. East Peoria, IL 61635 (309) 694-5398.

Right to Inspect and Copy Your Health Information: You may inspect and obtain a copy of your health information the Plan maintains. The requested information will be provided within 30 days if the information is maintained on site or within 60 days if the information is maintained offsite. A single 30-day extension is allowed if the Plan is unable to comply with the deadline. A written request must be provided to HIPAA Privacy Officer at Illinois Central College, 1 College Dr. East Peoria, IL 61635 (309) 694-5398. If you request a copy of your health information, the Plan may charge a reasonable fee for copying, assembling costs and postage, if applicable, associated with your request.

Right to Amend Your Health Information: You may request the Plan to amend your health information if you feel that it is incorrect or incomplete. The Plan has 60 days after the request is made to make the amendment. A single 30-day extension is allowed if the Plan is unable to comply with this deadline. A written request must be provided to HIPAA Privacy Officer, Illinois Central College, 1 College Dr. East Peoria, IL 61635 (309) 694-5398. Your request may be denied in whole or part and, if so, the Plan will provide you with a written explanation of the denial.

Right to an Accounting of Disclosures: You may request a list of disclosures made by the Plan of your health information during the

six years prior to your request (or for a specified shorter period of time), however, the list will not include disclosures made: (1) to carry out treatment, payment or health care operations; (2) disclosures made prior to April 14, 2004; (3) to individuals about their own health information; and (4) disclosures for which you provided a valid authorization.

A request for an accounting form must be used to make the request and can be obtained by contacting your HIPAA Privacy Officer at Illinois Central College, 1 College Dr. East Peoria, IL 61635 (309) 694-5398. The accounting will be provided within 60 days from your submission of the request form. An additional 30 days is allowed if this deadline cannot be met.

Right to Receive Confidential

Communications: You may request that the Plan communicate with you about your health information in a certain way or at a certain location if you feel the disclosure could endanger you. You must provide the request in writing to your HIPAA Privacy Officer at Illinois Central College, 1 College Dr. East Peoria, IL 61635 (309) 694-5398. The Plan will attempt to honor all reasonable requests.

Right to a Paper Copy of this Notice:

You may request a paper copy of this Notice at any time, even if you have agreed to receive this Notice electronically. Please contact your HIPAA Privacy Officer at Illinois Central College, 1 College Dr. East Peoria, IL 61635 (309) 694-5398 to make this request.

The Plan's Duties: The Plan is required by law to maintain the privacy of your health information as related in this Notice and to provide this Notice to you of its duties and

privacy practices. The Plan is required to abide by the terms of this Notice, which may be amended from time to time. The Plan reserves the right to change the terms of this Notice and to make the new Notice provisions effective for all health information that it maintains.

Complaints and Contact Person: If you wish to exercise your rights under this Notice, communicate with the Plan about its privacy policies and procedures, or file a complaint with the Plan, please contact the HIPAA Contact Person, at Illinois Central College, 1 College Dr. East Peoria, IL 61635 (309) 694-5398. You may also file a complaint with the Secretary of Health and Human Services if you believe your privacy rights have been violated.

Important Notice from Illinois Central College About Your Prescription Drug Coverage and Medicare (Creditable Coverage)

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Illinois Central College and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what

cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

2. Illinois Central College has determined that the prescription drug coverage offered by the Illinois Central College Plan is, on average for all plan participants, expected to pay out as much as standard Medicare

prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th.

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

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?

If you decide to join a Medicare drug plan, your current Illinois Central College coverage will not be affected.

If you do decide to join a Medicare drug plan and drop your current Illinois Central College coverage,

be aware that you and your dependents will be able to get this coverage back.

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with Illinois Central College and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

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

For More Information About This Notice Or Your Current Prescription Drug Coverage

Contact the person listed below for further information. **NOTE:** You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through Illinois Central College changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage

More detailed information about Medicare plans that offer prescription drug coverage is in the

"Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

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

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

Date: 7/19/18

Name of Entity/Sender: Illinois Central College

Contact--Position/Office: Human Resources

Phone Number: (309) 694-5398

Address: 1 College Dr. East Peoria, IL 61635

