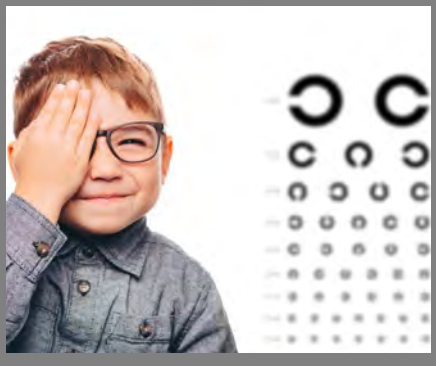
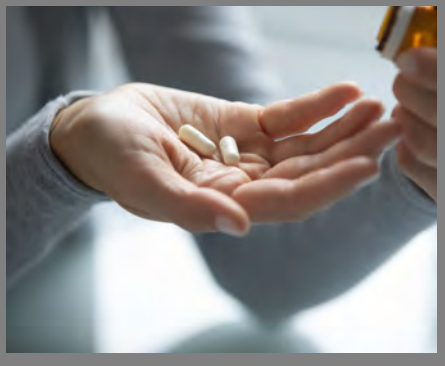
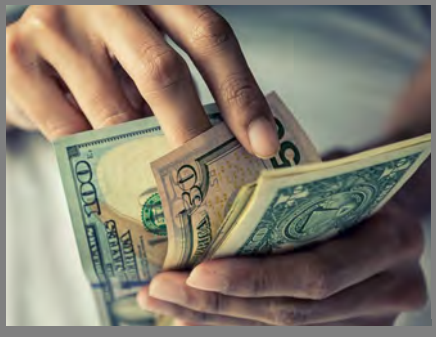
Employee Benefits Guide







January 2024 — December 2024

WCTC

WAUKESHA COUNTY TECHNICAL COLLEGE

Hands-on Higher Ed

Table of Contents

This document is an outline of the coverage proposed by the carrier(s), based on information provided by your company. It does not include all of the terms, coverage, exclusions, limitations, and conditions of the actual contract language. The policies and contracts themselves must be read for those details. Policy forms for your reference will be made available upon request.

The intent of this document is to provide you with general information regarding the status of, and/or potential concerns related to, your current employee benefits environment. It does not necessarily fully address all of your specific issues. It should not be construed as, nor is it intended to provide, legal advice. Questions regarding specific issues should be addressed by your general counsel or an attorney who specializes in this practice area.

Eligibility and Elections

About this Benefits Summary

Waukesha County Technical College offers a comprehensive benefits package to full and part time benefit eligible employees. The College offers a comprehensive suite of benefits to promote health and financial security for you and your family. The benefits package is briefly summarized in this Guide. Please review it carefully so you can choose the coverage that's right for you.

Please check your pay advice anytime you make changes to your benefits to ensure that your benefits and deductions reflect any changes made.

Eligibility

You're eligible for benefits as an active employee working at least 30 hours per week in a benefit eligible position unless stated otherwise in this Guide. Coverage for your benefits will start on the first of the month following the start date of employment.

Once the necessary enrollment forms have been completed, benefits are effective on your plan eligibility date.

New hires have up to 30 days from their eligibility date to enroll. If you do not enroll by the deadline, you may not be eligible again until the next annual open enrollment period or you have a qualified life event.

You may enroll your eligible dependents on some of the benefit plans.

Eligible Dependents Include:

- Your legal spouse as defined by the state in which you reside
- Your children up to age 26

Benefit Elections and Changes

Once elected, your benefits will be effective for the entire benefit plan year. You will have an opportunity to make changes to your benefit elections once a year during the annual open enrollment period. Outside of the open enrollment period, you may only make changes to your benefit elections if you experience a qualified life event.

Because many of your benefits are available on a pre-tax basis, the IRS requires you to have a qualified life event in order to make changes to your benefit elections during the plan year.

Qualified life events include:

- Marriage, divorce or legal separation
- Birth, adoption or placement for adoption
- Death of your spouse or dependent
- Significant change in your spouse's coverage

If you have a life event, you must make changes to your benefits within 30 days of the event. The change to your benefits must be consistent with the life event.

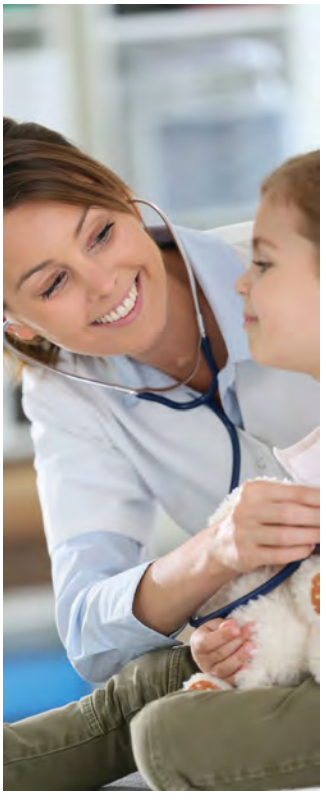
Medical Benefits

Administered by UMR

Comprehensive and preventive healthcare coverage is important in protecting you and your family from the financial risks of unexpected illness and injury. A little prevention usually goes a long way - especially in healthcare. Routine exams and regular preventive care provide an inexpensive review of your health. Small problems can potentially develop into large expenses. By identifying the problems early, often they can be treated at little cost.

	In Network	Out-of-Network
Calendar year deductible (embedded)		
Individual	$500	$600
Single + 1	$1000	$1,200
Family	$1,500	$1,800
Plan year out-of-pocket maximum (embedded)		
Individual	$1,500	$2,100
Single + 1	$3,000	$4,200
Family	$3,500	$5,300
Your costs for covered care		
Preventive Services	0% (100% covered by the plan)	20%
Office Visits *Primary Care*	$20 copay per visit	$20 copay per visit; 20% after deductible
Office Visits *Specialist*	$40 copay per visit	$40 copay per visit; 20% after deductible
Emergency Room (copay waived if admitted)	$200 copay per visit	$200 copay per visit
Urgent Care	$50 copay per visit	$50 copay per visit: 20% after deductible
Hospital & Surgical Services	Deductible; then 0% (100% covered by the plan)	Deductible; 20% after deductible
Diagnostic Lab & X-Ray *Office Setting*	Deductible; then 0% (100% covered by the plan)	Deductible; 20% after deductible
Prescription Drugs www.elixirsolutions.com		
Prescription Drug Out-Of-Pocket Maximum: $1,500 Single / $4,500 Family		
Tier One (Typically Generic)	Retail: $10 copay (30 days) Retail: $30 copay (90 days) Mail order: $20 copay (90 days)	Member is responsible for 100% of cost
Tier Two (Typically Preferred Brand)	Retail: $20 copay (30 days) Retail: $60 copay (90 days) Mail order: $40 copay (90 days)	Member is responsible for 100% of cost
Tier Three (Typically Non-Preferred Brand)	Retail: $40 copay (30 days) Retail: $120 copay (90 days) Mail order: $80 copay (90 days)	Member is responsible for 100% of cost
Tier Four (Specialty Drugs)	Tier 1: $10 copay Tier 2: $20 copay Tier 3: $40 copay (30 days)	Member is responsible for 100% of cost (30 days)

Embedded means that if Single + 1 or Family coverage is selected, an individual within that plan is not responsible for more than the embedded individual amount.



Save money with generic drugs!

Ask your doctor if it's appropriate to use a generic drug rather than a brand name drug. Generic drugs are less expensive, contain the same active ingredients, and are identical in dose and form as a brand name drug.

Online Tools & Network Resources

UHC Choice Plus Network
How to Find an In-Network Provider

www.umr.com

Learn how to find a medical provider on UMR.com and explore other features of UMR.com you can access when logging into your account by viewing this YouTube Video:

https://youtu.be/k_q7H0Z7dqQ

UMR Mobile – Stay Connected to your Health Plan

Take your insurance with you everywhere you go. You can log into the UMR mobile site using your smart phone, or view the full UMR site on your iPad or other tablet device.

The UMR mobile site offers quick and easy access to your claim, benefit information, ID cards, find a provider, and free wellness resources. There is no app to download and no waiting. Just go to umr.com on your mobile device to get started.

Take a video tour of the UMR site:

https://youtu.be/ZjHZwMm9ixM

The Alliance Network
(Madison/Dane County Residence)

https://the-alliance.org/

Click on Find a doctor

Enter your zip code and company name

Find network providers ~ compare costs ~ check quality ratings

Teladoc

NEW This Year!

Teladoc for Mental Health, Dermatology, and General Health for $10 copay

Teladoc gives you access to U.S. board-certified doctors through convenience of phone, video or mobile app visits 24/7/365. It's an affordable alternative to costly urgent care and ER visits when you need care now.

Teledoc		
General Health	**Mental Health**	**Dermatology**
$10 Copay	$10 Copay	$10 Copay

MEET THE DOCTORS

Teladoc is simply a new way to access qualified doctors. All Teladoc doctors:

- Are practicing PCPS, pediatricians and family medicine physicians
- Average 15 years experience
- Are U.S. board certified and licensed in your state
- Are credentialed every three years, meeting NCQA Standards
- Confidential therapy and care from wherever you are

GET THE CARE YOU NEED

Teladoc doctors can treat many medical conditions, including:

- Cold and flu symptoms
- Allergies
- Ear infection
- Urinary tract infection
- Respiratory infection
- Skin problems
- Anxiety, Depression, Stress
- Marital Issues

WHEN CAN TELADOC BE USED?

Teladoc does not replace your primary physician; it is convenient and affordable option for quality care.

- When you need care now
- If you're considering the ER or urgent care for a non-emergency issue
- On vacation, on a business trip or away from home
- For short term prescription refills

TELADOC™

Talk to a doctor anytime!

Teladoc.com

1-800-TELADOC (835-2362)

Download on the App Store

Download from Google Play

Dental Benefits

Administered by Delta Dental of Wisconsin

Regular trips to the dentist are essential for good oral health. Dental insurance may help considerably with the costs. But a great smile often requires additional dental care, such as x-rays, sealants and emergency oral evaluation.

Annual deductible	$55 Per Person $165 Per Family
Individual benefit maximum	$2,000
Diagnostic & Preventive Services (no deductible)	
Exams & Cleanings	100%
X-Rays	100%
Fluoride Treatments & Sealants	100%
Space Maintainers	100%
Basic Services (deductible applies)	
Fillings	80%
Root Canal Therapy	80%
Oral Surgery	80%
Major Services (deductible applies)	
Crowns (porcelain), Inlays, Onlays	80%
Bridges & Dentures	80%
Implants	80%
Orthodontic Services (no deductible)	
Adults and dependents covered until age 26	60% to $2,000 lifetime maximum

Enhanced Benefits Program

This program offers additional coverage for individuals who have specific health conditions (including pregnancy, diabetes, high-risk cardiac conditions, and suppressed immune systems) that can be positively affected by additional oral health care.

Helpful Tip: Minimize your out-of-pocket expense for dental care by asking your dentist for a pre-treatment estimate from Delta Dental before you agree to receive any prescribed major treatment.

Dental Provider Networks

As a Delta Dental member, you have the flexibility to choose any dentist with your Delta Dental plan – PPO, Premier or non-network. Your out-of-pocket costs will vary depending on the dentist you choose.

Note: Non-network dentists have not agreed to accept the PPO or Premier allowed amounts and can balance bill you.

Vision Benefits

Administered by Superior Vision

Even in today's economy, budgeting for regular eye exams is vital because early diagnosis and timely treatment of eye diseases - such as diabetic retinopathy, cataracts, and glaucoma - is made possible. Vision insurance can help defray the cost of those exams and treatment.

	In Network	Out-of-Network
Annual deductible	$0	$0
Benefits		
Exam	Covered in Full	Up To $35
Frames	$150 Retail Allowance (20% off amount over allowance)	Up To $75
Standard Lenses		
Single Vision	Covered In Full	Up To $25
Bifocal	Covered In Full	Up To $40
Trifocal	Covered In Full	Up To $45
Contact Lenses*		
Elective	$175 Retail Allowance	Up To $150
Medically Necessary	Covered In Full	Up To $150
Services/Frequency (based on date of service)		
Exam	Once per calendar year	
Frames	Once per 24 months	
Lenses	Once per calendar year	
Contact Lenses*	Once per calendar year	

** Contact lenses and related professional services (fitting, evaluation and follow-up) are covered in lieu of eyeglass lenses and frames benefit.*

Flexible Spending Accounts

Administered by Associated Benefits

FSAs allow you to use pre-tax dollars to pay for many health care expenses and dependent care expenses. The Health Care and Dependent Care FSA benefits are calendar year programs.

You decide how much you would like to set aside for health care expenses and/or dependent care expenses each year. That amount will be deducted from your paycheck on a pre-tax basis, so you save on income taxes and have more disposable income. That money is then credited to an individual "account" for you. You submit claims and are reimbursed from the account for your eligible expenses. **You must enroll for the entire year - the FSA plan year runs from January 1 through December 31.** Your election (payroll deduction amount) may not be changed during the year unless you have a qualified life event or change in status.

2024 Maximum Contribution Limits	
Health Care Account	$3,200
Dependent Care Account	$5,000

Health Care FSA

You can use the Health Care FSA for eligible health care expenses incurred by you, your spouse or any of your eligible dependents for certain medical, dental and vision expenses.

Eligible expenses include (but are not limited to):

- Deductibles, copays and coinsurance; over the counter medications
- Glasses and contact lenses not covered by a vision discount plan; laser eye surgery; hearing aids; and other expenses allowed by the IRS.
- Procedures performed for cosmetic reasons DO NOT qualify.

Remember: If you do not use up the health FSA money you contributed during the current plan year, you will be allowed to carry forward up to **$640** to use during the new plan year.

In addition, there is a 60-day period at the end of the plan year to submit incurred expenses.

Dependent Care FSA

You can use the Dependent Care FSA to pay for eligible daycare services. If you are married, you can use this account only if your spouse is employed or actively seeking work, is a full-time student for at least five months of the year, or is disabled.

You can pay daycare expenses for children under age 13, disabled children, disabled parents, a disabled spouse or relatives who qualify as dependents under the Internal Revenue Code. For your Dependent Care FSA contributions to be eligible for reimbursement, your provider must claim your payments as taxable income. Additional rules apply during leaves of absence for use.

Eligible daycare arrangements include (but are not limited to):

- Licensed nursery school and daycare centers for preschool children
- Day camps, after school care or in-home daycare for children under age 13
- Daycare centers for other qualifying dependents (elder care centers)
- Housekeepers, cooks or maids who provide dependent care in your home
- Individuals other than your dependents who provide daycare for your qualifying dependents, either inside or outside of your home

Associated Benefits Connection®

FILING A CLAIM TO PAY EXPENSES?
FINISH IN 3 EASY STEPS!

Complete the steps below to access your funds. It's that easy!

Step 1 – Collect your receipts and other documents.
Step 2 – Choose how to submit your claim.
See below for options and instructions.

Step 3 – Submit your request.
We'll review your claim and issue payment in 2-3 business days after approval. We'll notify you via the email address on file if we need additional information to approve your claim.

HOW TO SUBMIT YOUR CLAIM

PARTICIPANT PORTAL
- Click the **Pay Myself** button for direct deposit.
- Click the **Pay Someone Else** button to pay your provider, if your plan allows it.
- Upload your documentation.
- Complete all required fields.

MOBILE APP
- Tap the **Reimburse Myself** button for direct deposit.
- Tap the **Send Payment** button to pay your provider, if your plan allows it.
- Upload your documentation.
- Complete all required fields.

MAIL, EMAIL OR FAX
- Contact Participant Services for the request form or download from **Tools and Resources** in the portal.
- Complete all required fields and sign form.
- Include your documentation.
- Return using the contact information on the form.

Associated Bank
Your money works here.

Life Benefits

Administered by Symetra Life Insurance Company

Waukesha County Technical College provides basic life and accidental death and dismemberment (AD&D) insurance through Symetra Life Insurance Company at no cost to employees who work 20+ hours per week or more. If you want additional coverage for yourself, your spouse, or your children, you can purchase voluntary coverage at our group rates.

Basic Life and AD&D (Employer-paid benefit)	
Basic Life and AD&D Benefit	1 times Earnings

Employee Supplemental Life and AD&D (Employee-paid benefit)	
Life Benefit rate: premium schedule based on age and per $1,000/month	Option of 1 or 2 times Earnings*
AD&D Benefit rate: $0.02 per $1,000/month	Option of 1 or 2 times Earnings*

Dependent Supplemental Life (Employee-paid benefit)	
Life Benefit *Spouse*	$20,000
Life Benefit *Child(ren)*	14 days to 6 months: $1,000 6 months to 26 years: $10,000

Long-Term Disability Benefits

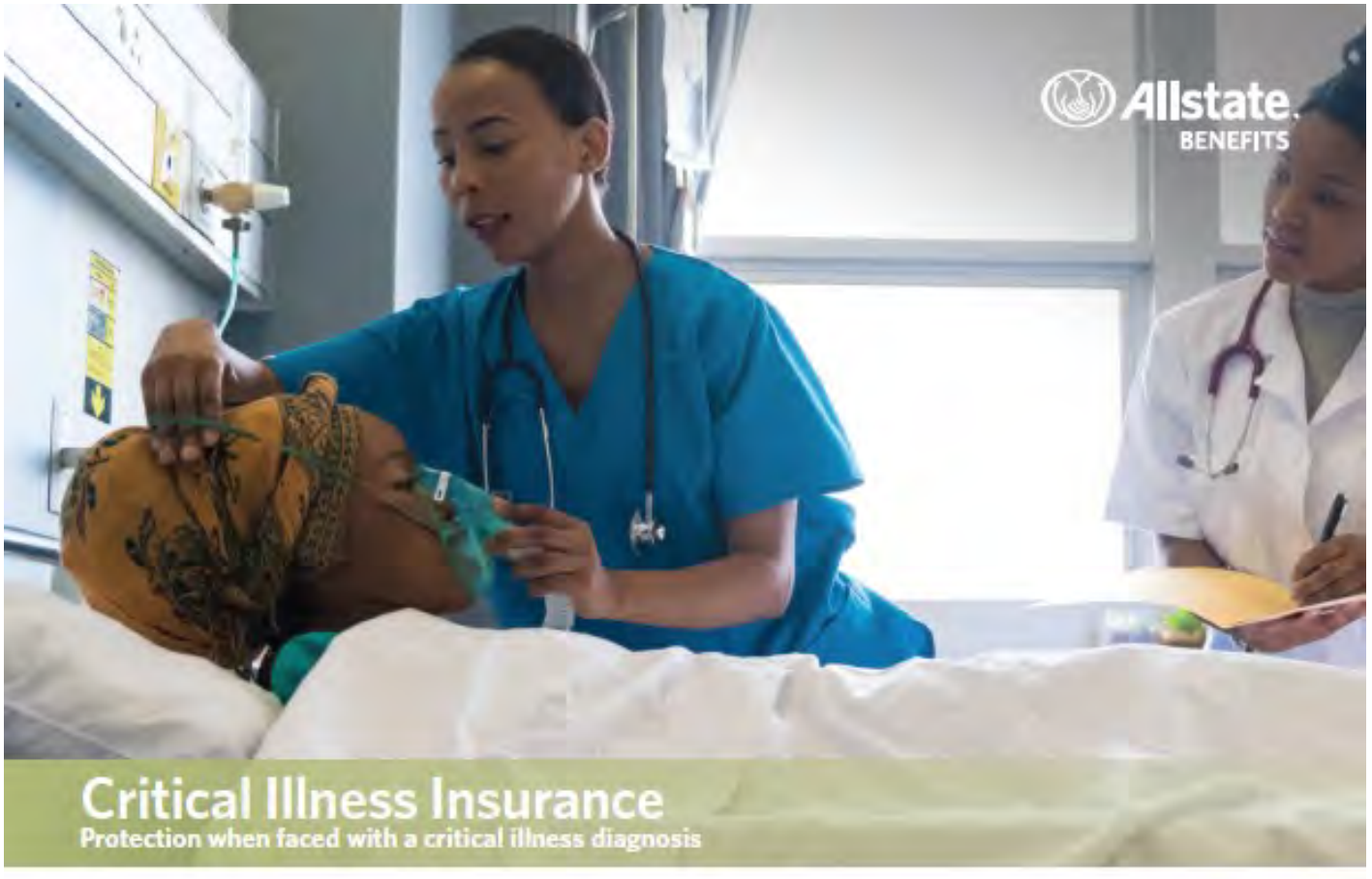
Administered by Madison National Life Insurance Company

Waukesha County Technical College provides long-term disability income benefits, and pays the full cost of this coverage.

Long-Term Disability (Employer-paid benefit)	
Eligibility	Employees who work 20 or more hours per week
Elimination Period	60 consecutive calendar days
Benefit	66 2/3% of monthly covered salary

Critical Illness

Administered by Allstate



THINK ABOUT THIS

Every 40 seconds, an American will suffer a heart attack†

Every 40 seconds, someone in the U.S. has a stroke†

Coverage offered to the employees of:

Waukesha County Technical College

If you're diagnosed with a critical illness and it keeps you out of work, the impact to your finances can grow quickly. Critical Illness Insurance from Allstate Benefits can help ease your mind so you can focus on getting better.

Here's How It Works

- Select a benefit and premium amount to meet your needs
- Premiums will be deducted each pay period
- If you're diagnosed with a critical illness, file a claim and receive a lump-sum cash benefit*

Protecting Your Finances

You've worked hard for your savings – don't let a critical illness wipe them out.

- Protect your checking and savings
- Don't dip into your HSA or 401(k)

✓ **Practical benefits for everyday living.•**

Meeting Your Needs

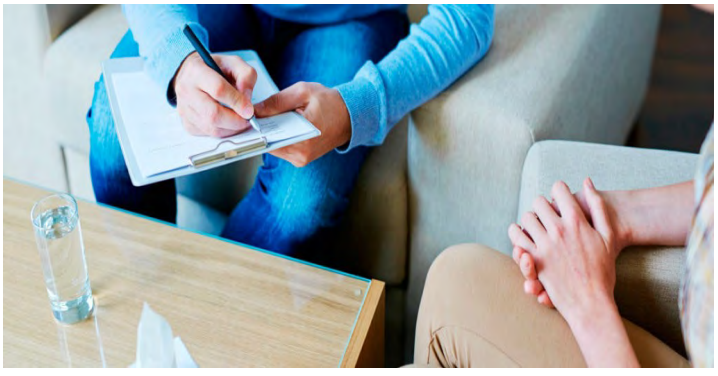
- Guaranteed Issue coverage without a Pre-Existing Condition Limitation*
- Coverage can include your dependents
- Benefits paid regardless of any other medical or disability plan coverage
- Coverage may be continued; refer to your certificate for details

†Heart Disease and Stroke Statistics—2023 Update: A Report From the American Heart Association. *Please refer to the Exclusions and Limitations section of this brochure.

Employee Assistance Program

Administered by Empathia, Inc.

WCTC provides an Employee Assistance and Work/Life Program called LifeMatters®. This free, confidential service is available to you and your immediate family members.



You and your immediate family members may call 1.800.634.6433, 24 hours a day, every day of the year to receive LifeMatters services. Professional counselors are available at all times to provide assistance to you and your eligible dependents for a wide range of issues, including:

- Family concerns
- Legal and financial questions
- Alcohol or drug abuse questions or problems
- Emotional or stress-related issues
- Family and dependent care needs
- Health and wellness insight
- Other personal problems

The program's counseling services are available at no cost to you and your immediate family members. Professional counselors are available both on the telephone and on an in-person basis in your local area. If additional counseling services are recommended, the LifeMatters counselor will assist you with accessing providers covered by our insurance plan.

Additional access to LifeMatters® is available through their web site at https://members2.mylifematters.com. The website provides work/life resource locators, financial calculators, health and wellness information, resources for locating child and elder care providers, self-assessment tests, and many additional resources. Please be assured that your privacy is strictly protected and information regarding your contact with LifeMatters® is private and will not be released to WCTC except in cases of imminent threat of harm, or when abuse of a child or vulnerable adult may be occurring.

If you have any questions about this new service, please contact Katie DeRemer 262.695.3454 in Human Resources or call LifeMatters® at 1.800.634.6433.

Visit the LifeMatters® Website now
Our company password on the MyLifeMatters website is WCTC1.

Legal Services

Administered by Hyatt Legal Plans, A MetLife Company

Cover the costs on a wide range of common legal issues with a Legal Plan.

Access experienced attorneys to help with estate planning, home sales, tax audits and more.

Legal experts on your side, whenever you need them

Quality legal assistance can be pricey. And it can be hard to know where to turn to find an attorney you trust. For a monthly fee, you can have a team of top attorneys ready to help you take care of life's planned and unplanned legal events.

MetLife Legal Plans gives you access to the expert guidance and tools you need to handle the broad range of personal legal needs you might face throughout your life. This could be when you're buying or selling a home, starting a family, dealing with identity theft or caring for aging parents.

Reduce the out-of-pocket cost of legal services with MetLife Legal Plans.

How it works

Our service is tailored to your needs. With network attorneys available in person, by phone or by email and online tools to do-it-yourself — we make it easy to get legal help. And, you will always have a choice in which attorney to use. You can choose one from our network of prequalified attorneys, or use an attorney outside of our network and be reimbursed some of the cost.[1]

Best of all, you have unlimited access to our attorneys for all legal matters covered under the plan. For a monthly premium conveniently paid through payroll deduction, an expert is on your side as long as you need them.

When you need help with a personal legal matter, MetLife Legal Plans is there for you to help make it a little easier.

Estate planning at your fingertips

Our website provides you with the ability to create wills, living wills and powers of attorneys online in as little as 15 minutes. Answer a few questions about yourself, your family and your assets to create these documents instantly. In states where available, you also have access to sign and notarize your documents online through our video notary feature.[2]

How to use the plan

1. Find an attorney

Create an account at **legalplans.com** to see your coverages, select an attorney and get a case number for your legal matter. Or, give us a call at **800.821.6400** for assistance.

2. Make an appointment

Call the attorney you select, provide your case number and schedule a time to talk or meet.

3. That's it!

There are no copays, deductibles or claim forms when you use a network attorney for a covered matter.

Helping you navigate life's planned and unplanned events.

For a monthly fee, you, your spouse and dependents get legal assistance for some of the most frequently needed personal legal matters — with no waiting periods, no deductibles and no claim forms when using a network attorney for a covered matter.

Money Matters	• Debt Collection Defense • Identity Management Services[3]	• Identity Theft Defense • Negotiations with Creditors • Personal Bankruptcy	• Promissory Notes • Tax Audit Representation • Tax Collection Defense
Home & Real Estate	• Boundary or Title Disputes • Deeds • Eviction Defense • Foreclosure	• Home Equity Loans • Mortgages • Property Tax Assessments • Refinancing of Home	• Sale or Purchase of Home • Security Deposit Assistance • Tenant Negotiations • Zoning Applications
Estate Planning	• Codicils • Complex Wills • Healthcare Proxies • Living Wills	• Powers of Attorney (Healthcare, Financial, Childcare, Immigration)	• Revocable & Irrevocable Trusts • Simple Wills
Family & Personal	• Adoption • Affidavits • Conservatorship • Demand Letters • Garnishment Defense • Guardianship • Immigration Assistance	• Juvenile Court Defense, Including Criminal Matters • Name Change • Parental Responsibility Matters • Personal Property Protection	• Prenuptial Agreement • Protection from Domestic Violence • Review of ANY Personal Legal Document • School Hearings
Civil Lawsuits	• Administrative Hearings • Civil Litigation Defense	• Disputes Over Consumer Goods & Services • Incompetency Defense	• Pet Liabilities • Small Claims Assistance
Elder-Care Issues	Consultation & Document Review for your parents: • Deeds • Leases	• Medicaid • Medicare • Notes • Nursing Home Agreements	• Powers of Attorney • Prescription Plans • Wills
Vehicle & Driving	• Defense of Traffic Tickets[4] • Driving Privileges Restoration	• License Suspension Due to DUI	• Repossession

To learn more about your coverages and see our attorney network, create an account at **legalplans.com** or call **800.821.6400** Monday – Friday 8:00 am to 8:00 pm (ET).

Your account will also give you access to our self-help document library to complete simple legal forms. The forms are available to you, regardless of enrollment.

Pet Insurance

Pet insurance from Nationwide®

With two budget-friendly options, there's never been a better time to protect your pet.

Our popular My Pet Protection® pet insurance plans now feature more choices and more flexibility

- **Get cash back on eligible vet bills:** Choose your reimbursement level of 50% or 70%[1]
- **Available exclusively for employees:** Plans with preferred pricing only offered through your company
- **Use any vet, anywhere:** No networks, no pre-approvals

Choose your level of coverage with My Pet Protection®

50% reimbursement — **$20-$35/month**[2]

70% reimbursement — **$27-$47/month**[2]

How to use your pet insurance plan

1. Visit any vet, anywhere.
2. Submit claim.
3. Get reimbursed for eligible expenses.

Get a quote at http://www.petinsurance.com/wctc • 877-738-7874

Some exclusions may apply. Certain coverages may be subject to pre-existing exclusion. See policy documents for a complete list of exclusions. Reimbursement options may not be available in all states.

[2]Starting prices indicated. Final cost varies according to plan, species and ZIP code.

Products underwritten by Veterinary Pet Insurance Company (CA), Columbus, OH; National Casualty Company (all other states), Columbus, OH. Agency of Record: DVM Insurance Agency. All are subsidiaries of Nationwide Mutual Insurance Company. Nationwide, the Nationwide N and Eagle, and Nationwide is on your side are service marks of Nationwide Mutual Insurance Company. ©2021 Nationwide. 21GRP8314

Nationwide®

Employee Premiums

Employee Supplemental Life			
Attained Age	**Monthly Rates per $1,000**	**Attained Age**	**Monthly Rates per $1,000**
Under 25	$0.077	50-54	$0.462
25-29	$0.077	55-59	$0.726
30-34	$0.088	60-64	$1.133
35-39	$0.110	65-69	$2.046
40-44	$0.165	70-74	$3.663
45-49	$0.286	75 and over	$3.663

Employee Supplemental AD&D	
Attained Age	**Monthly Rate Per $1,000**
All Ages	$0.02

Dependent Supplemental Life	
Attained Age	**Per Paycheck Rate Per Family Unit**
All Ages	$3.75

2024 Employee Contributions Per Paycheck (24 annual)

Medical *(All Full-Time: 30 hours + per week)*	
Employee	$78.96
Employee + 1	$153.74
Family	$221.61

Medical *(Associated Instructors: 32 hours per week)*	
Employee	$115.81
Employee + 1	$225.48
Family	$325.00

Dental *(All Full-Time)*	
Employee	$3.30
Family	$9.33

Dental *(Associated Instructors: 32 hours per week)*	
Employee	$4.83
Family	$13.66

Vision	
Employee	$3.82
Family	$10.29

Legal Services
$9.00

Pet Insurance
go to http://petinsurance.com/wctc for pricing information

2024 Employee Contributions
Monthly Rates

Critical Illness					
		Monthly		Monthly	
		Option 1 - $10,000		Option 2 - $20,000	
Tobacco Class	Attained Age	EE/EE + CH	EE + SP/F	EE/EE + CH	EE + SP/F
Non-Tobacco Rates	18-24	$2.65	$4.58	$4.04	$6.66
	25-29	$3.31	$5.57	$5.36	$8.67
	30-34	$4.40	$7.23	$7.58	$11.96
	35-39	$6.31	$10.09	$11.38	$17.69
	40-44	$8.64	$13.58	$16.03	$24.67
	45-49	$11.97	$18.58	$22.70	$34.67
	50-54	$16.42	$25.26	$31.61	$48.01
	55-59	$21.68	$33.16	$42.13	$63.81
	60-64	$30.83	$46.87	$60.43	$91.23
	65-69	$43.10	$65.29	$84.96	$128.06
	70-74	$58.92	$89.00	$116.60	$175.52
	75-79	$75.55	$113.93	$149.83	$225.36
	80+	$108.54	$163.42	$215.83	$324.37
Tobacco Rates	18-24	$2.97	$5.07	$4.69	$7.64
	25-29	$3.67	$6.11	$6.07	$9.74
	30-34	$5.43	$8.78	$9.63	$15.06
	35-39	$8.27	$13.03	$15.30	$23.56
	40-44	$11.67	$18.12	$22.07	$33.74
	45-49	$17.44	$26.78	$33.63	$51.07
	50-54	$25.32	$38.60	$49.38	$74.68
	55-59	$34.41	$52.23	$67.56	$101.97
	60-64	$49.55	$74.96	$97.87	$147.41
	65-69	$70.08	$105.76	$138.93	$209.01
	70-74	$95.04	$143.19	$188.83	$283.86
	75-79	$117.28	$176.54	$233.30	$350.57
	80+	$159.04	$239.18	$316.83	$475.86

Employee Time Off

Vacation Time Off

Year 1	15 Days
Year 2	20 Days
Year 3	21 Days
Year 4	22 Days
Year 5	23 Days
Year 6	24 Days
Year 7+	25 Days

*prorated based on FTE

up to 5 days can be rolled over

Sick Time Off

14 Days for Staff

12 Days for Faculty

Max Sick Day Accumulation

100 Days for Staff

90 Days for Faculty

4 days can be used as personal days

Marketplace

Benefits With Gallagher Marketplace

Giving you year-round access to additional benefits that could save you money.

Gallagher Marketplace is your gateway for discovering and accessing unique benefits that best fit your lifestyle. Our program offers significant savings on things you are already buying—like home and auto, renters insurance, boat or RV insurance, as well as extended vehicle warranties.

With a centralized hub, you can explore an array of benefit options, available not only to Gallagher clients but also to their friends and families.

Discover what bene its your organization offers through Gallagher Marketplace.

The Value

- Whether full-time, part-time or contract workers, all employees and their families are eligible
- Benefit access and potential savings through bundling with the ability to choose from multiple carriers
- Potential costs savings compared to shopping on your own
- Licensed insurance advisors to help find the policy that meets your needs

The Convenience

- Enroll any time of the year, not just during open enrollment
- Simple sign-up with payment options
- Easily compare rates from multiple carriers
- Schedule a callback from licensed insurance advisors for a time that's most convenient
- All programs are portable so you can keep the coverage no matter where life takes you

How It Works

1. Visit Gallagher Marketplace to see your available benefits.
2. Select a product to view more details.
3. Click on the partner link to learn more, get a free no obligation quote or apply for coverage.

Scan the QR code to learn more

AJG.com **The Gallagher Way.** Since 1927.

PerkSpot

What is the WTC Discount Program?

Your WTC Discount Program is a one-stop-shop for thousands of exclusive discounts in more than 25 different categories. That means there's something for everyone!

How to Navigate Your Discount Program

Perks Near You
Located in the New & Featured section, Perks Near You allows you to use your location to see all of the discounts near you, wherever you are! Discounts can be filtered by category and distance.

Personalized Savings
Let us know what you're interested in so we can ensure you're seeing the perks you'll most enjoy, front and center on your Discount Program Home Page.

Brands Fit For Every Lifestyle
Looking for something specific? The Brands page, found in the Popular Perks section, is an easy and quick way to search for all of the discounts available to you.

Suggest a Business
Don't see what you're looking for? Head to the Suggest a Business page, found in the upper right-hand corner of your Home Page under Account Options, to suggest your favorite brands and local spots be added to your Discount Program.

Dedicated Support
PerkSpot's customer support team is here to help with any questions. We've included important information regarding our availability should you need assistance!

We're Here to Help

Hours
Monday - Friday
8:00 AM - 6:00 PM CST

Phone Number
866-606-6057

Email
cs@perkspot.com

Help Center*
support.perkspot.com

*Our bilingual Customer Service team can answer any questions in both English and Spanish

Ready to save? Head to wtc.perkspot.com to get started!
Use access code *WTCPerks* on the registration page

Contact Information

If you have specific questions about any of the benefit plans, please contact the administrator listed below. You may also reach out to your dedicated HR Business Partner or email hrservices@wctc.edu.

Benefit	Administrator	Phone	Website
Medical	UMR	800-826-9781	www.umr.com
Prescription	Elixir Customer Service Mail Order Specialty	800-361-4542 866-909-5170 877-437-9012	www.elixirsolutions.com
Dental	Delta Dental	800-236-3712	www.deltadentalwi.com
Vision	Superior Vision	800-507-3800	www.superiorvision.com
Flexible Spending Account (FSA)	Associated Bank	800-270-7719	Associated Benefits Connection: https://participantbenefits.associatedbank.com
Life and AD&D	Symetra Life Insurance Company	800-796-3872	www.symetra.com
Long-Term Disability	Madison National Life Insurance Company	800-356-9601	www.madisonlife.com
Critical Illness	Allstate	800-521-3535	www.allstate.com
Employee Assistance Program (EAP)	Empathia, Inc.	800-634-6433	www.members2.mylifematters.com Password: WCTC1
Legal Services	Hyatt Legal Plans / MetLife	800-821-6400	www.legalplans.com
Pet Insurance	Nationwide	877-738-7874	www.petinsurance.com/wctc

Important Notices

Newborns' and Mothers' Health Protection Act

Group health plans and health insurance issuers 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 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 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, 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).

Women's Health & Cancer Rights Act

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

- All 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 the plan.

If you would like more information on WHCRA benefits, please call Human Resources.

HIPPA Notice of Privacy Practices Reminder

Waukesha County Technical College is committed to the privacy of your health information. The administrators of the Waukesha County Technical College Health Plan (the "Plan") use strict privacy standards to protect your health information from unauthorized use or disclosure.

The Plan's policies protecting your privacy rights and your rights under the law are described in the Plan's Notice of Privacy Practices. You may receive a copy of the Notice of Privacy Practices by contacting Human Resources.

HIPAA Special Enrollment Rights

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

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

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

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

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

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

Important Warning

If you decline enrollment for yourself or for an eligible dependent, you must complete our form to decline coverage. On the form, you are required to state that coverage under another group health plan or other health insurance coverage (including Medicaid or a state children's health insurance program) is the reason for declining enrollment, and you are asked to identify that coverage. If you do not complete the form, you and your dependents will not be entitled to special enrollment rights upon a loss of other coverage as described above, but you will still have special enrollment rights when you have a new dependent by marriage, birth, adoption, or placement for adoption, or by virtue of gaining eligibility for a state premium assistance subsidy from Medicaid or through a state children's health insurance program with respect to coverage under this plan, as described above. If you do not gain special enrollment rights upon a loss of other coverage, you cannot enroll yourself or your dependents in the plan at any time other than the plan's annual open enrollment period, unless special enrollment rights apply because of a new dependent by marriage, birth, adoption, or placement for adoption, or by virtue of gaining eligibility for a state premium assistance subsidy from Medicaid or through a state children's health insurance program with respect to coverage under this plan.

Important 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 January 31, 2024. 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 ProgramWebsite: 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)
CALIFORNIA – Medicaid
Health Insurance Premium Payment (HIPP) Program http://dhcs.ca.gov/hipp Phone: 916-445-8322 Fax: 916-440-5676 Email: hipp@dhcs.ca.gov

COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+: https://www.colorado.gov/pacific/hcpf/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/ State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.colorado.gov/pacific/hcpf/health-insurance-buy-program HIBI Customer Service: 1-855-692-6442
FLORIDA – Medicaid
Website: https://www.flmedicaidtplrecovery.com/ flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268
GEORGIA – Medicaid
A HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162, Press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization- act-2009-chipra Phone: (678) 564-1162, Press 2
INDIANA – Medicaid
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: https://www.in.gov/medicaid/ Phone 1-800-457-4584
IOWA – Medicaid and CHIP (Hawki)
Medicaid Website: https://dhs.iowa.gov/ime/members Medicaid Phone: 1-800-338-8366 Hawki Website: http://dhs.iowa.gov/Hawki Hawki Phone: 1-800-257-8563 HIPP Website: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp HIPP Phone: 1-888-346-9562
KANSAS – Medicaid
Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884
KENTUCKY – Medicaid
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov
LOUISIANA – Medicaid
Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)

Important Notices

MAINE – Medicaid
https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: -800-977-6740. TTY: Maine relay 711
MASSACHUSETTS – Medicaid and CHIP
Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840
MINNESOTA – Medicaid
https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp Phone: 1-800-657-3739
MISSOURI – Medicaid
http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005
MONTANA – Medicaid
http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084
NEBRASKA – Medicaid
Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
NEVADA – Medicaid
Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900
NEW HAMPSHIRE – Medicaid
Website: https://www.dhhs.nh.gov/oii/hipp.htm Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345,ext 5218
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://medicaid.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: https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx Phone: 1-800-692-7462
RHODE ISLAND – Medicaid and CHIP
Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIteShare Line)
SOUTH CAROLINA – Medicaid
Website: https://www.scdhhs.gov Phone: 1-888-549-0820
SOUTH DAKOTA - Medicaid
Website: http://dss.sd.gov Phone: 1-888-828-0059
TEXAS – Medicaid
Website: 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
Website: https://www.coverva.org/en/famis-selecthttps://www.coverva.org/en/hipp Medicaid Phone: 1-800-432-5924 CHIP Phone: 1-800-432-5924
WASHINGTON – Medicaid
Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022
WEST VIRGINIA – Medicaid and CHIP
Website: https://dhhr.wv.gov/bms/ http://mywvhipp.com/ Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
WISCONSIN – Medicaid and CHIP
https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002
WYOMING – Medicaid
Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since January 31, 2024, 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

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 1/31/2024)

Notice of Creditable Coverage

Important Notice from Waukesha County Technical College About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Waukesha County Technical 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. Waukesha County Technical College has determined that the prescription drug coverage offered by the medical 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 Waukesha County Technical College coverage If you decide to join a Medicare drug plan, your current Waukesha County Technical College coverage will not be affected. When this plan is not primary, the Plan will coordinate benefits with Medicare.

If you do decide to join a Medicare drug plan and drop your current Waukesha County Technical College coverage, be aware that you and your dependents may not 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 Waukesha County Technical 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.

Important Notices

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 Waukesha County Technical 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).

COBRA General Notice

Introduction

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

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

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

What is COBRA continuation coverage?

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

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

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

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

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

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

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Plan as a "dependent child."

When is COBRA continuation coverage available?

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

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

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. You must provide this notice to: Nikki (Nicole) Dobson.

How is COBRA continuation coverage provided?

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

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

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

Disability extension of 18-month period of COBRA continuation coverage

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

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

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

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, Medicare, Medicaid, Children's Health Insurance Program (CHIP), 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/.

Can I enroll in Medicare instead of COBRA continuation coverage after my group health plan coverage ends?

In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period[1] to sign up for Medicare Part A or B, beginning on the earlier of

- The month after your employment ends; or
- The month after group health plan coverage based on current employment ends.

If you don't enroll in Medicare and elect COBRA continuation coverage instead, you may have to pay a Part B late enrollment penalty and you may have a gap in coverage if you decide you want Part B later. If you elect COBRA continuation coverage and later enroll in Medicare Part A or B before the COBRA continuation coverage ends, the Plan may terminate your continuation coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if you enroll in the other part of Medicare after the date of the election of COBRA coverage.

If you are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer) and COBRA continuation coverage will pay second. Certain plans may pay as if secondary to Medicare, even if you are not enrolled in Medicare.

For more information visit https://www.medicare.gov/medicare-and-you.

[1] https://www.medicare.gov/sign-up-change-plans/how-do-i-get-parts-a-b/part-a-part-b-sign-up-periods.

If you have questions

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

Important Notices

Keep your Plan informed of address changes

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

Plan contact information

Waukesha County Technical College
Nikki (Nicole) Dobson – Sr. HR Business Partner
800 Main Street
Pewaukee, Wisconsin 53072-4601
262.691.5193

Marketplace Notice

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 and employment-based health coverage offered by your employer.

What is the Health Insurance Marketplace?

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

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

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

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

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5% of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.[2]

[2] 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.

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 Nikki (Nicole) Dobson

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

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

If you decide to shop for coverage in the Marketplace, HealthCare.gov will guide you through the process.

Your Rights and Protections Against Surprise Medical Bills

When you get emergency care or get treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from surprise billing or balance billing.

What is "balance billing" (sometimes called "surprise billing")?

When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, such as a copayment, coinsurance, and/or a deductible. You may have other costs or have to pay the entire bill if you see a provider or visit a health care facility that isn't in your health plan's network.

"Out-of-network" describes providers and facilities that haven't signed a contract with your health plan. Out-of-network providers may be permitted to bill you for the difference between what your plan agreed to pay and the full amount charged for a service. This is called "**balance billing**." This amount is likely more than in-network costs for the same service and might not count toward your annual out-of-pocket limit.

"Surprise billing" is an unexpected balance bill. This can happen when you can't control who is involved in your care—like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider.

You are protected from balance billing for:

Emergency services

If you have an emergency medical condition and get emergency services from an out-of-network provider or facility, the most the provider or facility may bill you is your plan's in-network cost-sharing amount (such as copayments and coinsurance). You **can't** be balance billed for these emergency services. This includes services you may get after you're in stable condition, unless you give written consent and give up your protections not to be balanced billed for these post-stabilization services.

Certain services at an in-network hospital or ambulatory surgical center

When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers may bill you is your plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers **can't** balance bill you and may **not** ask you to give up your protections not to be balance billed.

If you get other services at these in-network facilities, out-of-network providers **can't** balance bill you, unless you give written consent and give up your protections.

You're never required to give up your protections from balance billing. You also aren't required to get care out-of-network. You can choose a provider or facility in your plan's network.

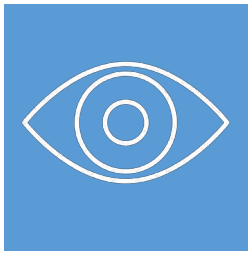
When balance billing isn't allowed, you also have the following protections:

You are only responsible for paying your share of the cost (like the copayments, coinsurance, and deductibles that you would pay if the provider or facility was in-network). Your health plan will pay out-of-network providers and facilities directly.

Your health plan generally must:

- Cover emergency services without requiring you to get approval for services in advance (prior authorization).
- Cover emergency services by out-of-network providers.
- Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits.
- Count any amount you pay for emergency services or out-of-network services toward your deductible and out-of-pocket limit.

If you believe you've been wrongly billed, you may contact the plan administrator.



This benefit summary prepared by

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Insurance | Risk Management | Consulting