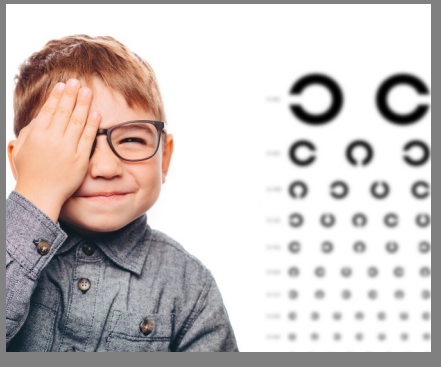
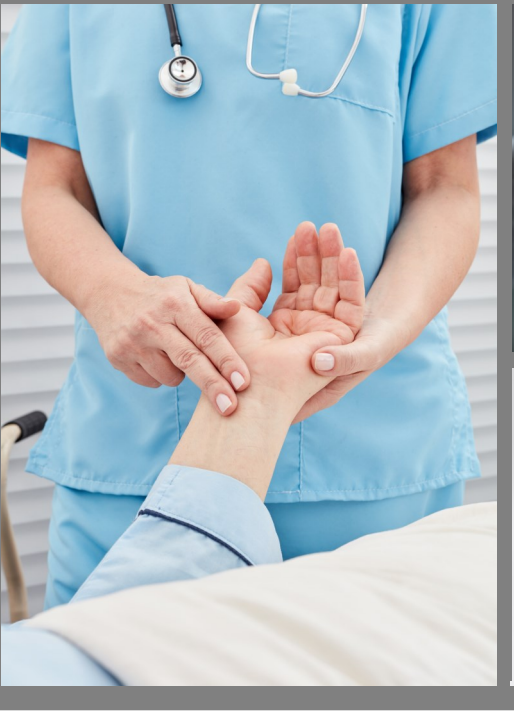
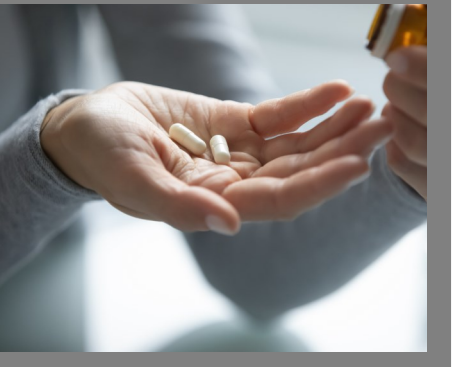
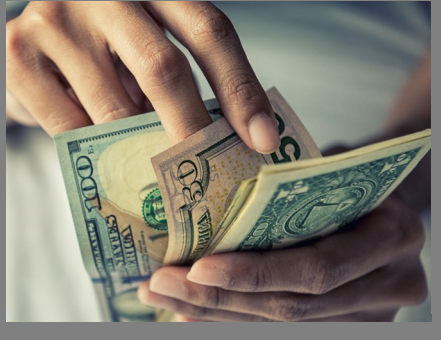
LAKESHORE COLLEGE

Employee Benefits Guide


January 2025 - June 2025

Revised 11/4/24

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Eligibility and Enrollments

About this Benefits Guide

Lakeshore takes pride in being an employer of choice; offering a benefits program that is balanced, cost effective and competitive. The College offers a comprehensive suite of benefits to promote health and financial security for you and your family, designed for your financial protection. This booklet provides you with a summary of your benefits. Please review it carefully to choose the coverage that's right for you.

Eligibility

As a Lakeshore employee, you are eligible for full-time benefits if you are full-time exempt, work 1,560 hours in a non-exempt staff role or 1,440 annual hours in a full-time faculty role. Benefits are effective the first of the month coinciding with or following date of hire (Exception: If the 1st or 2nd falls on a weekend, coverage may begin 1st of current month). The enrollment form must be completed within 31 days from the date of eligibility.

You may enroll your eligible dependents for coverage once you are eligible. Your eligible dependents include:

- Your legal spouse
- Your children up to age 26

Qualified Life Events

Generally, you may make your benefit elections only during the annual open enrollment period. However, you may change your benefit elections during the year if you experience a qualified life event, including:

- Marriage
- Divorce or legal separation
- Birth of your child
- Death of your spouse, or dependent child
- Adoption or placement for adoption of your child
- Change in employment status of employee, spouse, or dependent child.
- Qualification by the plan administrator of a child support order for medical coverage
- Entitlement to Medicare or Medicaid

You must notify Human Resources within 31 days of the qualifying life event. Depending on the type of event, you may be asked to provide proof of the event. If you do not contact Human Resources within 31 days of the qualifying event, you lose the opportunity to come onto the plan until the next annual open enrollment period.

Cost of Your Benefits

Lakeshore College pays the full cost of many of your benefits; you share the cost for others. You pay the full cost for any voluntary benefits you elect.

Benefit	Tax Treatment	Who Pays
Health Coverage	Pre-Tax	Lakeshore and You
Dental Coverage	Pre-Tax	Lakeshore and You
Basic Life	Taxable Fringe Over $50,000	Lakeshore
Supplemental Life Insurance Coverage	Post-Tax	You
Long-Term Disability	N/A	Lakeshore
Short-Term Disability	Post-Tax	You
Vision Coverage	Pre-Tax	You
Employee Assistance Program (EAP)	N/A	Lakeshore
Flexible Spending Accounts	Pre-Tax	You
Wisconsin Retirement System (WRS)	Pre-Tax	Lakeshore and You
Retirement Options (403b and 457)	Pre-Tax and/or Post-Tax (Roth)	You
Critical Illness	Post-Tax	You
Accident	Post-Tax	You
529 College Savings	Pre-Tax	You

Eligibility

The College provides a comprehensive benefit package to employees who are hired for regular full-time positions, working a minimum of 30 hours per week. Employees hired to regular part-time positions are eligible for a different benefit package. The chart below outlines the benefits for each benefit group. Payroll deductions maybe established for premium payments, when applicable, in accordance with state and federal guidelines.

Part-time, adjunct, or those employees working on an as-needed basis may be eligible for limited benefits but are not eligible for payroll deductions.

Benefit	Regular Full-Time	Regular Part-Time	Other
Insurance:			
Health & Telemedicine	X		
Alternative Benefit Plan (ABP)	X		
Dental	X		
Vision	X		
Group Life Insurance	X	X	
Long-Term Disability	X		
Short-Term Disability	X	X	
Leaves:			
Vacation	X	X	
Holiday	X	X	
Paid Leave of Absence	X	X	
Personal	X	X	
Family Medical Leave (FMLA) / Matched Leave for new child/new grandchild	X	X	
Employee Assistance Program (EAP)	X	X	X
Flexible Spending	X		
Life-Long Learning	X	X	
Professional Development	X	X	
Retirement:			
Wisconsin Retirement System (WRS)	X	X	X
403(b) & 457	X	X	X
Tuition Reimbursement	X	X	
Voluntary Deductions	X	X	
Workers' Compensation	X	X	X

LAKESHORE COLLEGE

Health Insurance

Comprehensive and preventive healthcare coverage is important in protecting you and your family from the financial risks of unexpected illness and injury. Lakeshore College offers the following health plan option. The plan includes comprehensive health care benefits, including coverage for prescription drugs and free preventative care services.

★ The Health plan is a self-funded health plan with UMR as the third-party administrator. UnitedHealthcare Choice Plus Network is the network used for in Network level of benefits. Prescription Drug Coverage is provided through OptumRx.

	In-Network	Non-Network
Calendar Year Deductible (embedded)*		
Individual	$1,500	$4,000
Family	$3,000	$8,000
Calendar Year Out-Of-Pocket Maximum (embedded) - Medical and Prescription Drug COMBINED		
Individual	$4,000	$8,000
Family	$8,000	$16,000
Your costs for covered care		
Preventive Services	Covered 100% by Lakeshore	Deductible, then 40%
Office Visits Primary & Specialty	$35 copay / $70 copay	Deductible, then 40%
Emergency Room Care	$350 copay	$350 copay
Urgent Care	$50 copay	Deductible, then 40%
Hospital & Surgical Services	Deductible, then 20%	Deductible, then 40%
Diagnostic Lab & X-Ray	Deductible, then 20%	Deductible, then 40%
Prescription Drugs OptumRx https://www.optumrx.com/oe_premium/landing		
Generic Drugs (Tier 1)	30-Day Retail: $10 copay 90-Day Retail: $30 copay 90-Day Mail Order: $20 copay	Not Covered
Preferred Brand Drugs (Tier 2)	30-Day Retail: $30 copay 90-Day Retail: $90 copay 90-Day Mail Order: $60 copay	Not Covered
Non-Preferred Brand Drugs (Tier 3)	30-Day Retail: $60 copay 90-Day Retail: $180 copay 90-Day Mail Order: $120 copay	Not Covered
Specialty Drugs (Tier 4)	Non-Preferred: $200 copay	Not Covered

The deductible, co-insurance, and co-payments applied to your in-network and non-network maximum out-of-pocket limits accumulate separately and are not transferable.

*All medical and prescription drug expenses will track towards a combined in network medical and prescription drug out of pocket maximum of $4,000/$8,000.

How To Find A Provider

With a preferred provider plan, using the network provider maximizes your benefits. You can find a network provider by clicking on the Find a Provider link at www.umr.com, then search for the United HealthCare Choice Plus network, which includes a Medical Provider or a Behavioral Health Provider. If you go to the provider outside this network, you will likely have higher out-of-pocket costs.

Case Management - A valuable part of your medical benefits

UMR Care Management is a staff of experienced, caring nurses (RNs) who help you get the most out of your health plan benefits. They work with you, your doctors, and other medical advisors to get the services that best meet your needs. Whether you're having a baby, have an emergency hospitalization or need non-emergency care, UMR Care Management Nurses will be available to assist you by:

- Helping negotiate treatment from the beginning of your care to recovery
- Helping you look at treatment needs and options under the direction of your doctor
- Serving as your advocate with your benefits administrator
- Providing an understanding of any complex issues to your claim's payer
- Helping you better understand your health benefits

If you have questions about your Care Management benefits or upcoming healthcare services, call UMR Care Management at the phone number provided on your member ID card.

Contact:	UMR | 800-826-9781
Bridge:	The Bridge □ Administration □ Human Resources □ Benefits □ Health, Real Appeal, and Prescription

Remember to call ahead

Make sure you're covered before receiving care

Any time you or a family member is admitted to the hospital or receives certain outpatient services, it is important to let UMR know. We want to make sure you receive the appropriate care and that you understand whether your benefit plan will pay for any portion of the treatment cost.

You or your health care provider can call the number on the back of your medical ID card to verify the level of benefits available. Our decisions are for payment purposes only. All decisions about the types of care you receive remain between you and your providers.

There are two reasons you or your provider should call UMR before a medical service or procedure:

Prior authorization of care

Some types of care require a review to determine if they are medically necessary. This means they meet generally accepted standards of care and are considered effective in treating your illness or injury. We also review if the length of your inpatient stay and type of facility are clinically appropriate.

Failure to obtain prior authorization may result in a penalty or increased out-of-pocket costs.

Predetermination of benefits

We recommend you and your health care provider also call ahead regarding treatments that do not require a review. This is to verify the amount, if any, your medical plan will pay toward the cost of care you plan to receive.

Any payment for an expense that is not covered under the plan is the patient's responsibility.

We will send a letter to you and your provider, notifying you whether the treatment is covered.

Procedures we commonly review:[1]

- Inpatient hospitalization and surgeries[2]
- Inpatient rehabilitation and behavioral health
- Skilled nursing facility
- Home health care
- Durable medical equipment
- Radiology services such as MRA, MRI, PET and CT scans
- Chemotherapy and radiation
- Dialysis
- Occupational, speech or physical therapy
- Transplants and transplant related services
- Reconstructive surgeries and cosmetic procedures
- Clinical trials and experimental procedures
- Genetic testing
- Hormone therapies
- Specialty injectable drugs

1- This list is not all-inclusive. Please refer to your summary plan description (SPD) for a full list of services requiring prior authorization. UMR pays providers according to the coverage terms, benefits, limitations and exclusions of your benefit plan documents.

2- Except stays of 48 hours or less following a normal vaginal delivery or 96 hours or less following a Cesarean section.

UMR

A UnitedHealthcare Company

Teladoc

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.

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

GET THE CARE YOU NEED

Teladoc doctors can treat many medical conditions, including:

- Cold and flu symptoms
- Allergies
- Sinus problems
- Ear infection
- Urinary tract infection
- Respiratory infection
- Skin problems
- And more!

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

Real Appeal

Weight issues in the U.S. have reached epidemic proportions. It's estimated nearly 7/10 adults are considered overweight or obese.

Available through UMR, Real Appeal can help you reverse this trend, with tools and support to help employees lose weight, feel good and prevent weight-related health conditions. Real Appeal uses a highly interactive weekly online show, videos, and live online coaching to drive small behavior changes, week by week, over a full year.

Participants receive one-on-one support through online consultations with a personal coach and interactive group discussions. They also receive digital tools for desktop and mobile devices and a weight-loss kit with exercise DVDs, an electronic scale, a pedometer, a blender, calorie and weight-loss trackers, fitness guides and more. There is NO cost to members to participate.

Eligible Members must fall into one of the following:

- Body Mass Index (BMI) - greater than 30.
    - Your BMI is your weight (in kilograms) over your height squared (in centimeters). Let's calculate, however, using pounds and inches. For instance, the BMI of a person who is 5'3" and weighs 125 lbs. is calculated as follows: Multiply the weight in pounds by 0.45 (the metric conversion factor).
- Greater than 25 but not more than 29.9 BMI with qualifying co-morbidity (diabetes, dyslipidemia, High-blood pressure, pre-diabetes, tobacco user).
- Greater than 23 but not more than 29.9 BMI with co-morbidity.

The Real Appeal Program Includes:

Coaching

- One-on-one coaching with a weight-loss expert and weekly group coaching and live online discussion

Personalized Support

- Tools to help support success based in individualized needs:
    - Nutrition guides, meal plans, recipes, shopping lists and tips for dining out, Video workouts and fitness Guides

Tools and Tracking

- Hands-on tools tailored to participant needs.
- Online support tools, including educational websites and digital applications.
- Online or mobile tracking tools to monitor nutrition and exercise – such as changing moods, cravings, feelings of satiety, exercise, and food intake.

ENROLL by going to www.getreal.realappeal.com. When you begin your enrollment, have your insurance information and calendar handy to choose your weekly online session day and time.

Contact:	UMR | 800-826-9781
Bridge:	The Bridge □ Administration □ Human Resources □ Benefits □ Health, Real Appeal, and Prescription

Opt Out & Spousal Surcharge

Alternate Benefit Program and Opt Out

Employees eligible for Lakeshore's health insurance plan who have waived coverage, may be eligible to receive an alternative benefit program payment via payroll.

Requirements for Eligibility

- Full Time Staff eligible for health insurance.
- Documented evidence of other health coverage must be provided to the college (Employer Letter or a copy of the insurance card) along with a signed Health Insurance Opt-Out Request form upon initial election.
- Confirmation of continued coverage will be requested each year and employees must complete a new Health Insurance Opt-Out Request from during open enrollment or with their initial enrollment.

Payment

The ABP allows eligible participants, with coverage elsewhere, to waive Lakeshore's health insurance coverage and receive a monthly payment of $200. Supporting documentation received after the enrollment period will delay receipt of the opt-out stipend until the first pay period of the following month. The stipend will not be retroactively paid.

Bridge:	The Bridge Administration Human Resources Benefits Opt-Out Health - Alternative Benefit Plan

Spousal Surcharge

A spousal surcharge is an additional premium an employee is required to pay if their spouse has an alternative source for healthcare coverage through their own employer yet elects to be added to the employee's plan.

Lakeshore College employees are subject to a $100 per month surcharge to cover a spouse who is eligible for group health coverage through his/her own employer (other than through Lakeshore College), or a spouse who is retired and has access to a health plan through his/her previous employer (other than through Lakeshore College). If at any point your spouse ceases to be eligible for his/her employer's health coverage, he/she may be enrolled under the Lakeshore College health plan coverage within 30 days from such loss of eligibility.

Any employee enrolling a spouse onto the Lakeshore plan will be required to complete a Spouse Health Insurance Coverage Statement, regardless if other coverage is available.

Contact:	Debbie Sosnosky | 920-693-1163 | Debbie.Sosnosky@gotoltc.edu
Bridge:	The Bridge Administration Human Resources Benefits Spouse Health Insurance Coverage Statement Request from HR

Spenddown Health Reimbursement Arrangement

Employees enrolled in the Lakeshore health insurance plan prior to 2024 had the opportunity to participate in an incentive-based HRA program, earning funds toward reimbursement of qualified health-related expenses*. Funds earned from January 1, 2023, through November 30, 2023, will be placed in a Spenddown HRA.

What is a Spenddown HRA?
A Spenddown HRA is an account that allows you to be reimbursed for qualifying health-related expenses*. The name "spenddown" is used because the account is never added to, only spent down until depleted.

How do I access my funds?
You will need to submit a reimbursement request to UMR to utilize any funds in the Spenddown HRA. There is no debit card available for expenses.

What if I am no longer enrolled in the Lakeshore health plan?
If you are no longer enrolled in the Lakeshore medical plan, you will forfeit your Spenddown HRA funds. Anyone enrolled in the Lakeshore health plan via COBRA will continue to have access.

Additional information regarding your Spenddown HRA:

- Funds remain within the Spenddown HRA for two years, or until December 31, 2025, whichever is sooner.
- Funds not used on or before December 31, 2025, will be forfeited.

How do I check my balance?
To stay updated on your spending account claims, payments, balances, eligible expenses, and other important information, please log in to your account on the UMR website (umr.com).

*Based on current IRS guidelines for Section 213(d) expenses

Flexible Spending Accounts

YOUR BENEFITS. OUR KNOWLEDGE.

FLEXIBLE SPENDING ACCOUNT

Using a flexible spending account (FSA) is great way to stretch your benefit dollars. You use before-tax dollars in your FSA to reimburse yourself for eligible out-of-pocket medical and dependent care expenses. That means you can enjoy tax savings and increased take-home pay—all with the convenience of a prepaid benefits card.

What is an FSA?

With an FSA, you elect to have your annual contribution deducted from your paycheck each pay period, in equal installments throughout the year, until you reach the yearly maximum you have specified. The amount of your pay that goes into an FSA will not count as taxable income, so you will have immediate tax savings. FSA dollars can be used during the plan year to pay for qualified expenses and services.

- A Healthcare FSA allows reimbursement of qualifying out-of-pocket medical expenses.
- A Dependent Care FSA allows reimbursement of dependent care expenses (such as daycare) incurred by eligible dependents.

With all FSA account types, you'll receive access to a secure, easy-to-use web portal where you can track your account balance, view your claims history, and submit requests for reimbursements.

With an FSA you can:

- Enjoy significant tax savings with pre-tax contributions and tax-free reimbursements for qualified plan expenses.
- Pay expenses quickly and easily using the prepaid benefits card at the point of sale, or request to have funds directly deposited to your bank account via the online or mobile app.
- Reduce filing hassles and paperwork by using your prepaid benefits card.
- Access your accounts using our secure online Consumer Portal 24/7/365.
- Manage your FSA "on the go" with an easy-to-use mobile app.
- File claims for reimbursement (when required) in the online portal or the mobile app. You can also use the camera on your mobile device to scan an EOB in Smart Scan, and the app will prefill data to make it even easier.
- Stay up to date on balances and required actions with automated alerts and convenient portal and mobile app messages.

Grace Period

When enrolled in the Health Care Account and/or the Dependent Care Account as of the end of the Plan Year, you are eligible for a two-and-a-half-month grace period (January 1 to March 15). The grace period allows you and your dependents (if applicable) to continue incurring medical care expenses and dependent care expenses for up to two-and-a-half months following the end of the plan year. Those expenses will be reimbursed with any remaining account funds from the prior year. During the "grace period," prior-year funds will be used for reimbursement before funds from the new plan year.

Important Information About FSAs

Claims for reimbursement must be submitted by March 15th of the following year. This is known as the "use it or lose it" rule and it is governed by IRS regulations. FSA elections do not automatically continue from year to year; you must actively enroll each year.

Account Type	Eligible Expenses	2025 Annual Contribution Limits*	Benefit
Health Care Account (HCA)	Medical, Dental, Vision care expenses not covered by insurance (co-insurance, glasses, contacts, deductibles)	Maximum contribution $3,300 per year	Saves on eligible expenses reduces your taxable income
Dependent Care Account (DCA)	Dependent care expenses (day care, after school programs or elder care programs)	Maximum contribution $5,000 per year	Reduces your taxable income.

Contact:	https://www.associatedbank.com | 800-236-8866
Bridge:	LTC Bridge Administration Human Resources Benefits (Flexible Spending & Rollover)

Flexible Spending Accounts

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.

AssociatedBank
Your money works here.

Contact:	https://www.associatedbank.com | 800-236-8866
Bridge:	LTC Bridge Administration Human Resources Benefits (Flexible Spending & Rollover)

Flexible Spending Accounts

Associated Benefits Connection®

Frequently Asked Questions (FAQs)

Q: What documentation is required in order to pay my expense?

A: Benefit accounts can vary from plan to plan, but in general, any documents you submit should include this information:

- Name of provider or merchant where product or service was received.
- Name of person who received the product or service.
- Description of the product or service.
- Date(s) of service.
- Amount paid.
- For prepaid orthodontia claims—your orthodontic treatment plan and contract.

You aren't required to submit documentation for HSA (health savings account) transactions, but you should keep records of the expenses you reimburse.

Q: What account type should I select for my claim?

A: When filing your claim online or on the mobile app, use the following account types:

- Health Reimbursement Arrangements (HRAs) = Medical
- Flexible Spending Accounts (FSAs) = Medical
- Limited Purpose Flexible Spending Accounts = Medical
- Dependent Care = Dependent Care
- Mass Transit = Transportation and Parking
- Parking = Transportation and Parking
- Lifestyle Spending Account (LSAs) = LSA

Q: What is the deadline to file my claim?

A: For benefit accounts, this varies from plan to plan. You can find the final filing date in your plan documents. As the deadline approaches, the portal and the mobile app will display these dates to help you remember to get your claims in on time. Participant Services can also provide this information.

Questions?
We're here for you!

Contact us at 800-270-7719 or email ParticipantServices@AssociatedBank.com

AssociatedBank
Your money works here.

Contact:	https://www.associatedbank.com | 800-236-8866
Bridge:	LTC Bridge Administration Human Resources Benefits (Flexible Spending & Rollover)

Exciting News: We are now offering access to Teladoc Health's Chronic Condition Management Services!

We're thrilled to share details about several new health benefits that are now available to you through Teladoc Health and UMR. These programs will give eligible members access to connected health management devices, certified health coaches and mental health coaches – all to help manage conditions like diabetes, hypertension, diabetes prevention and weight challenges. **These benefits are provided at no cost to you.**

Programs offered:

Diabetes Management	Hypertension Management	Diabetes Prevention

*Weight Management services may be included in any of the programs above.

How does it work?

When eligible members enroll, the benefits may include:

- **Coaching on your schedule.** Expert health coaches are ready to help you. Together you'll create a custom plan to meet your needs and focus on health areas that are important to you.
- **Connected devices.** For those who are eligible, you will get a blood glucose meter and/or a blood pressure monitor that automatically uploads your readings at no cost to you. You may also be eligible for a smart scale. Track your progress and manage your health all within a private account on an easy-to-use app.
- **Digital behavioral health support.** Get 24/7 access to practical tips and tools that may help you better manage stress, sleep, anxiety, depression and more.
- **Safety and security.** Your information is safe with Teladoc Health. Look at your records anytime on the app. Share it with your doctors when and if you want to.

Getting started with Chronic Condition Management is easy:

Already registered for Teladoc Health?	New to Teladoc Health?
• Simply log-in to your account via the Teladoc Health app or TeladocHealth.com • Select "Condition Management" to discover the support for your needs	• Download the Teladoc Health app or visit TeladocHealth.com and create your account • Once you complete registration, select "Condition Management" to find what benefit fits your needs

Diabetes Management
- ✓ Connected meter
- ✓ Unlimited strips and lancets

Hypertension Management
- ✓ Connected monitor
- ✓ One-on-one coaching

Diabetes Prevention
- ✓ Connected scale
- ✓ Expert guidance

...And more programs!
- ✓ Health experts
- ✓ Personalized plans

Dental Insurance

Regular dental exams can help you and your dentist detect problems in the early stages when treatment is simpler, and costs are lower. Keeping your teeth and gums clean and healthy will help prevent most tooth decay and periodontal disease and is an important part of maintaining your medical health.

★ Lakeshore offers you a self-funded dental plan with Delta Dental of Wisconsin.

Annual deductible	$0
Annual maximum (per person)	$2,000
Diagnostic & Preventive Services	
Exams & Cleanings	100%
X-rays	100%
Fluoride Treatments & Sealants	100%
Basic Services	
Fillings	80%
Root Canal Therapy	80%
Oral Surgery	80%
Major Services	
Crowns, Inlays, Onlays	80%
Bridge/denture/implant repair	50%
Bridges, Dentures, Implants	50%
Orthodontic Services	
Adults and Dependents (to age 26)	50% to $2,000 lifetime maximum

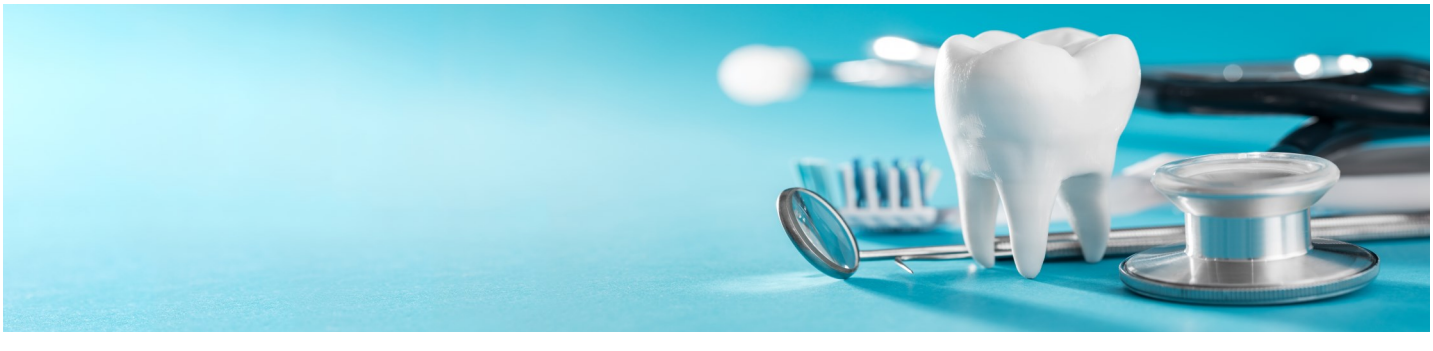
Enhanced Benefits Program

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

Your lowest out-of-pocket costs will come from seeing a Delta Dental PPO dentist. That means savings on out-of-pocket costs and better choice. Non-network dentists may balance bill you for amounts over the plan percentages of coverage. Avoid balance billing by using network providers.



Contact:	Delta Dental | 800-236-3712 | www.deltadentalwi.com
Bridge:	The Bridge □ Administration □ Human Resources □ Benefits □ (Benefit Summaries, Summary Plan Descriptions, & Dental & Vision Discount)

LAKESHORE COLLEGE

Vision Insurance

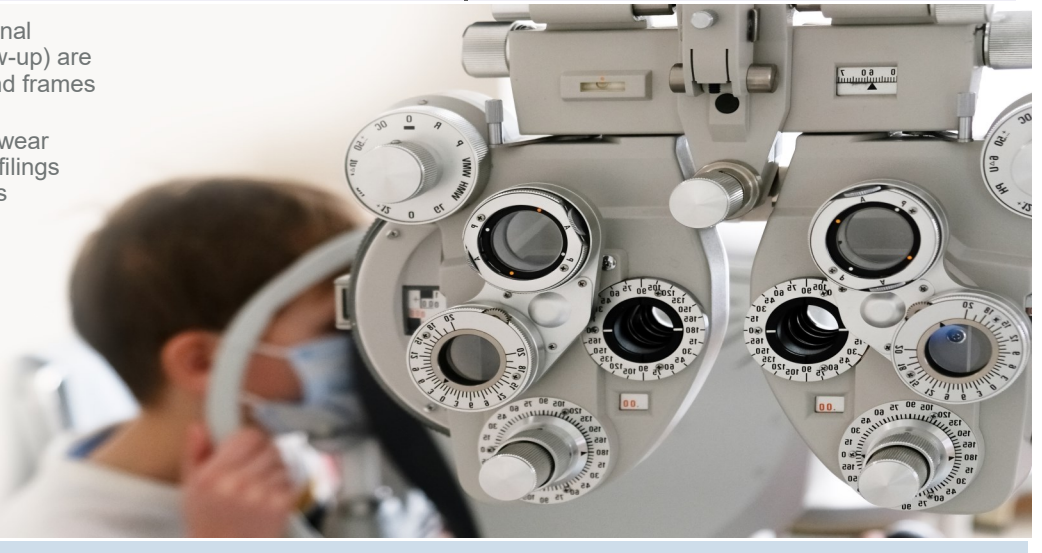
Even in today's economy, budgeting for regular eye exams is vital because early diagnosis and timely treatment of eye diseases - such as diabetic retinopathy, cataracts and glaucoma - is made possible. Vision Insurance can help defray the cost of those exams and treatment.

★ The Vision plan is with Superior Vision as the carrier.
Superior Select Midwest Network is the network used for in Network level of benefits.

	Exam and Materials Plan		Materials Only Plan	
	In Network	Out-of-Network	In Network	Out-of-Network
Annual deductible	$0	$0	$0	$0
Benefits				
Exam	Covered In Full	Up to $35	Not Covered	Not Covered
Frames	$150 Retail Allowance	Up to $75	$150 Retail Allowance	Up to $75
Standard Lenses				
Single Vision	Covered In Full	Up to $25	Covered In Full	Up to $25
Bifocal	Covered In Full	Up to $40	Covered In Full	Up to $40
Trifocal	Covered In Full	Up to $45	Covered In Full	Up to $45
Contact Lenses[1]				
Elective	$175 Retail Allowance	Up to $150	$175 Retail Allowance	Up to $150
Medically Necessary	Covered In Full	Up to $150	Covered In Full	Up to $150
LASIK Vision Correction[2]	$200 Allowance	$200 Allowance	$200 Allowance	$200 Allowance
Services/Frequency				
Exam	one per calendar year		N/A	
Frames	one per calendar year		one per calendar year	
Lenses	one pair per calendar year		one pair per calendar year	
Contact Lenses*	one allowance per calendar year		one allowance per calendar year	

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

[2] Lasik Vision Correction in lieu of eyewear benefit, subject to routine regulatory filings and certain exclusions and limitations



Contact:	Superior Vision | 800-879-6901 | www.superiorvision.com
Bridge:	Lakeshore Bridge □ Administration □ Human Resources □ Benefits □ Vision

Vision Discount Program

Your dental plan from Delta Dental includes a vision care discount program. Delta Dental of Wisconsin has chosen EyeMed Vision Care® as the network provider for your vision care discount program. EyeMed offers you a choice of services at a great value. This is not insurance, but a discount plan that provides:

- Overall savings up to 35%
- Savings on laser vision correction
- Replacement contact lenses by mail
- Access to thousands of private practice and retail providers nationwide, including Lens Crafters®, Target Optical®, Shopko Optical®, and most Pearle Vision® locations.
- Choice of any product, including designer brand-name frames (certain brands impose a no-discount policy and the frame discount is not available).

Vision Discount Program	Member Benefit
Exam with Dilation as Necessary	$5 off comprehensive exam $10 off contact-lens exam
Complete Pair Glasses Purchased Apply only if a complete pair is purchased in the same transaction. Items purchased separately are discounted 20% off the retail price.	
Frames: Any frame available at provider location	35% off retail price
Single Plastic Lenses Including Standard Scratch Coating Single-Vision Bifocal Trifocal	Member Pays $50 $70 $105
Lens Option UV Coating Tint (solid and gradient) Standard Polycarbonate Standard Anti-Reflective Coating Standard Progressive (add-on to bifocal)	Member Pays $15 $15 $40 $45 $65
Conventional Contact Lenses: Applied to materials only	15% off retail price
Laser Vision Correction: LASIK or PRK	15% off retail price or 5% off promotional price
Frequency: Exams, frames, lenses, and contact lenses	Unlimited

Additional Notes

After initial purchase, replacement contact lenses may be obtained online at substantial savings and mailed directly to the member. Members will receive a 20% discount on items purchased at participating providers not included under the program and may not be combined with any other discounts or promotional offers. The discount does not apply to EyeMed provider's professional services or contact lenses. Prices may vary by location.

Plan Limitations/Exclusions:

- Orthoptic or vision training, subnormal vision aids, and associated supplemental testing
- Medical and/or surgical treatment of the eye, eyes, or supporting structures
- Corrective eyewear required by an employer as a condition of employment, and safety eyewear
- Services provided as a result of Worker's Compensation

Contact:	EyeMed Vision Care | 866-800-5457 | www.eyemedvisioncare.com/deltadental
Bridge:	The Bridge □ Administration □ Human Resources □ Benefits (Dental & Vision Discount)

Life Insurance & Disability

Group Basic Life Insurance

Lakeshore offers various life insurance options through Symetra Life Insurance Company. All active employees working a minimum of 23 hours each week (excluding temporary, leased, or seasonal) have a life insurance policy paid by Lakeshore equal to one times their annual salary.

*Reduction in coverage due to age applies to basic life insurance and supplemental life insurance. Reductions are effective on September 1st following the date you attain age 70, 75, and 80.

Group Supplemental Life and Accidental Death & Dismemberment (AD&D) Insurance

Supplemental term life insurance for the employee is available in amounts of $25,000, $50,000, $75,000, and $100,000 coverage (Includes Accidental Death & Dismemberment). This is group term insurance which means the cost of the coverage increases as an employee enters a new age bracket. This coverage is available on a voluntary payroll deduction basis. Enrollment may require underwriting.

Group Life Insurance Monthly Rates:

Age Bracket	$25,000	$50,000	$75,000	$100,000
Up to 34	$2.14/mo.	$4.26/mo.	$6.38/mo.	$8.50/mo.
35-39	$2.64	$5.26	$7.88	$10.50
40-44	$3.64	$7.26	$10.88	$14.50
45-49	$5.38	$10.76	$16.14	$21.50
50-54	$8.38	$16.76	$25.14	$33.50
55-59	$12.38	$24.76	$37.14	$49.50
60-64	$13.88	$27.76	$41.64	$55.50

* Please note reduction in coverage due to age applies to basic life insurance and supplemental life insurance. Reductions will be effective on September 1st following the date you attain age 70, 75, and 80.

Voluntary Dependent Life Insurance

Voluntary dependent life insurance is available for your spouse and unmarried dependent children. The child's coverage extends from 15 days of age to age 26 or older and disabled.

Family Plan 1	Family Plan 2
$2 premium per month	$4 premium per month
$7,500 spouse and/or $3,750 per child	$15,000 spouse and/or $7,500 per child

Long-Term Disability (LTD)

100% Employer paid Long Term Disability Insurance is offered through National Insurance Services (NIS). LTD insurance provides a non-taxable benefit of 67% of your base salary in the event you become disabled and are unable to work after 90 consecutive calendar days of disability.

Benefit Amount	67% of Base Earnings, maximum amount applies
Benefit Duration	Benefits are payable up to age 65; those over 65 have limits on the duration of the benefit
Elimination Period	90 days

Contact Human Resources if you need to get started on completing a long-term disability claim.

Contact:	Debbie Sosnosky | 920-693-1163 | Debbie.Sosnosky@gotoltc.edu
Bridge:	The Bridge □ Administration □ Human Resources □ Benefits (Life & Long-Term Disability)

Additional Programs

Since we carry our life insurance through Symetra, they offer additional free benefits for our employees including travel assistance, identity theft protection, and beneficiary assistance. Each of these services is only a phone call away 24/7.

Travel Assistance

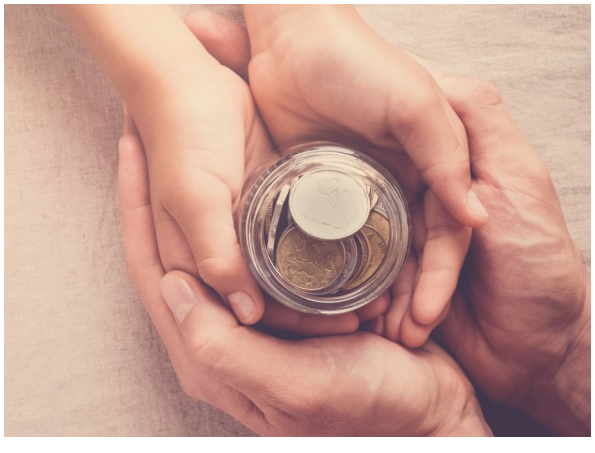
Your Travel Assistance Program offers a variety of 24-hour-a-day services in more than 200 countries and territories worldwide for emergency help. Services under this program include finding medical services, free transportation when medically necessary, free transportation home for traveling companion's and dependent children, replacement of medication and eyeglasses. Other services include help locating/replacing lost or stolen luggage, documents and personal possessions, legal assistance, telephone interpretation in all major languages, and much more. When calling, be prepared to provide the address where you are staying, a phone number where we may reach you, and your employer's name.

Contact:	Symetra| 877-823-5807 (US) 240-330-1422 (from anywhere else in the world)
Bridge:	The Bridge Administration Human Resources Benefits (Miscellaneous) "Value Added Programs through Symetra"

Identify Theft Protection Program

Identity theft is a rising concern, and it can happen to anyone. That's where your Identity Theft Protection Program comes in. It provides you with information to protect yourself and step-by-step coaching to help you confirm and resolve identity theft. The Identity Theft Protection Program is provided by Generali Global Assistance. If you think your identity has been stolen, call 24 hours a day, seven days a week. An Identity Theft Expert will help you obtain a copy of your credit report from all three major credit-reporting agencies and put a fraud alert on your records. The services also include lost wallet assistance, credit information review, translation services, emergency cash advance while traveling (a repayment guarantee is needed).

Contact:	Symetra | 877-823-5807 (US) 240-330-1422 (from anywhere else in the world)
Bridge:	The Bridge Administration Human Resources Benefits (Miscellaneous) "Value Added Programs through Symetra"



Beneficiary Companion Program

Managing a loved one's final affairs can be overwhelming. The amount of time and effort needed to close an estate can make an already stressful time even more difficult. Your Beneficiary Companion Program can offer some relief and provide guidance to help with paperwork, notifications, and other time-consuming details.

The Beneficiary Companion Program is provided by Generali Global Assistance. Dedicated beneficiary assistance coordinators are available 24/7 to answer any questions, offer guidance on how to obtain death certificate copies, manage notifications such as social security administration, credit reporting agencies, credit card companies/financial institutions, third-party vendors, and government agencies.

Contact:	Symetra | 877-823-5807 (US) 240-330-1422 (from anywhere else in the world)
Bridge:	The Bridge Administration Human Resources Benefits (Miscellaneous) "Value Added Programs through Symetra"

Voluntary Plans

Available for employees working 1,200+ annual hours

Voluntary accident and critical illness insurance are optional coverages that employees can choose to enroll in. They provide financial protection in case of accidents or critical illnesses, helping to cover medical expenses and alleviate financial burdens.

These benefits offer:

- Group plans with lower costs, increased benefits and guaranteed issue
- Cash that can be used for leftover medical bills, everyday living expenses and replacement of household income
- Fixed rates for the life of the coverage
- Individual ownership and portability

Accident Coverage– Allstate

This voluntary benefit prepares you for those unexpected expenses associated with an accident. Paid benefits include:

- Initial treatment with/without X-ray
- Follow-up treatment
- Initial hospitalization
- Daily hospital confinement
- Major diagnostic exam
- Epidural pain management
- Physical therapy/Rehabilitation
- Ambulance (actual charges incurred)
- Transportation
- Day family lodging
- Accidental dismemberment
- Annual Wellness Screening Benefit, one per covered person, per calendar year
- Pays regardless of other insurance

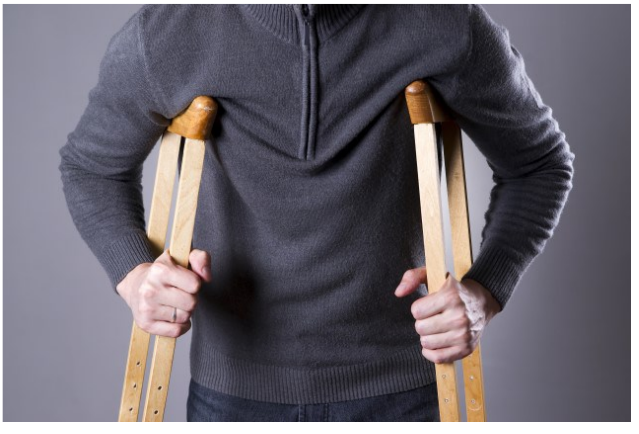
Lump Sum Critical Illness– Allstate

- This is a lump sum option between $10,000 and $30,000 for an upfront payout in the event of a covered illness
- Covered critical illnesses include cancer, sudden cardiac arrest, heart attack, stroke, end stage renal failure, major organ transplant, and bone marrow transplant
- Re-occurrence benefit
- Coronary artery bypass surgery benefit
- Health screening benefit for employee and spouse
- Can help with out-of-network expenses that may be associated with specialized care

Short-Term Disability—Aflac

Like accidents, disabilities can happen when least expected. If an employee is unable to work for days or months due to a disability, this benefit may help meet financial obligations like house or rent payments, groceries, and utility bills.

- The plan stays with you even when you change or leave your job
- Monthly benefits: $300-$5,000 (subject to income requirements)
- Benefit period: 3 months
- Elimination period (injury/sickness): 0/7 days



Bridge:	The Bridge Administration Human Resources Benefits Aflac/Allstate/Teladoc

Employee Support

Employee Assistance Programs (EAP) (National Insurance Services & Symetra)

Sometimes life can be challenging. That's why Lakeshore provides Employee Assistance Programs (EAP) to all eligible employees at no cost to you. The EAP is designed to provide prompt, confidential help for a range of personal and family issues that may affect all of us from time to time. You can receive up to three in-person assessment and counseling sessions with masters-degreed counselors, 24-hours a day. Assistance by phone is available immediately. The EAP program also provides legal, financial, childcare and eldercare assistance.

Contact:	National Insurance Services | 866-451-5465 | www.niseap.com Log in: NISEAP I Password: EAP (case-sensitive)
Bridge:	The Bridge Administration Human Resources Benefits (Miscellaneous)

Mental Wellbeing

When your mental health is off, or the mental health of someone close to you, you want to get help to make it better. These confidential resources can support you and your loved ones during times of mental health struggles.

HOPELINE™ serves anyone in any type of situation, providing them with access to free, 24/7 emotional support and information--before situations rise to a crisis level. Text HOPELINE (741741) anywhere, anytime.

988 – Suicide and Crisis Lifeline. Call or text for support for anyone in suicidal crisis or mental-health-related distress.

Mental Health America. Offers a wide-range of treatments and supports, including mental health screening tools. For more information, find them at www.mentalhealthamerica.net.

Prevent Suicide Wisconsin. Affiliated with Mental Health America to provide local resources for suicide support and resources. You may call, text, chat, or visit https://www.preventsuicidewi.org/resources for additional resources.

Manitowoc County – (920)683-4230 or (888)552-6642 (after hours)
Sheboygan County – (920)459-3151

NAMI (National Alliance on Mental Illness) or NAMI - Wisconsin. Mental illness can affect a person's thinking, feeling, or mood, impacting the ability to relate to others, focus, and/or function**.** Both organizations provide support, education, and resources for those affected by any type of mental illness.

Teladoc – available to anyone on Lakeshore's health insurance, this resource also offers confidential access to mental health professionals. Teladoc.com or 1-800-TELADOC (835-2362).

Bridge:	The Bridge Administration Human Resources Benefits (Mental Health Resources)

Hours and Payroll

Family & Medical Leave (FMLA)

Employees may be eligible for up to 12 weeks of unpaid leave for the employee's serious health or family member's condition. Employees are eligible once they have been employed for one year and worked a minimum of 1,000 hours.

Workers' Compensation Insurance

Worker's compensation insurance is maintained by Lakeshore to cover on-the-job injuries of all employees. Accidents should be reported immediately to your supervisor and Human Resources Department. Accidents should be reported immediately to your supervisor and the Human Resources Department.

Refreshment & Lunch Breaks

Employees are allowed a break of up to 15 minutes in the morning and a break of up to 15 minutes in the afternoon for refreshments. This time may not be used to leave the office earlier or to lengthen the lunch break period. Employees, whose work schedule exceeds six hours must take a half hour nonpaid lunch. Employees opting to exercise daily can add 15 minutes onto one daily, regularly scheduled break, with their manager's approval. The entire 30 minutes would be paid and dedicated to physical activity.

Payroll

Your payroll is made by direct deposit on or before the 15th and the last business day of the month. If the 15th or last day of the month fall on a weekend or holiday, pay will be issued on the scheduled work day prior.

Voluntary Deduction Participation Options

Pre-Tax Payroll Deduction:

- Flexible Spending Accounts
- Health and Dental Employee portion
- Wisconsin Retirement System (WRS)
- Tax-Sheltered annuity plans (403b) *
- Deferred compensation plan (457) *
- Vision

After Tax Payroll Deduction:

- Child Care
- Foundation (scholarship donation)
- Life Insurance -Voluntary Supplemental & Dependent
- Short Term Disability (STD), Accident & Critical Illness
- United Way
- Tax-Sheltered annuity plans (403b) *
- Deferred compensation plan (457) *

Voluntary deductions will be withheld from both mid-month and end-of-the-month payrolls for regularly scheduled full-time and part-time employees. Both pre-tax and after tax options available.

Contact:	Kim Schad| 920-693-1869 | Kim.Schad@gotoltc.edu

Time Off Benefits
Fiscal Year July 1 to June 30

LAKESHORE COLLEGE

Paid Leave of Absence (PLOA)

PLOA is given at the beginning of each fiscal year. It is used for illness and medical/dental appointments of the staff member or family member, funeral and birth or adoption of a child. "Family" means spouse, children, stepchildren, parents, stepparents, siblings, parents-in-law, grandparents and grandparents-in-law, grandchildren and any person living at the employee's home receiving emotional and financial support, who is considered by the staff member as a lifelong family member. This definition of family does not include acquaintances, friends, or roommates.

All full and eligible part time employees will receive 9 days of PLOA on July 1 each year. Prorated time is provided to regularly scheduled part-time employees based on the number of annual work hours. First year employees will receive prorated leave, effective on the first day of employment

PLOA	Faculty — 9 days	Exempt/Non-Exempt Staff — 9 days

Personal Leave

Some PLOA hours may be used for non PLOA circumstances such as family graduations and/or marriages; appointments such as legal, financial, business, and school closings; special school events that are only scheduled during work hours; home appliance, equipment, or structural problems; and car malfunctions. Six days will be provided each fiscal year to eligible employees and are deducted from the PLOA balance when used.

Personal	Faculty — 6 days	Exempt/Non-Exempt Staff — 6 days

Bereavement (Funeral Leave)

Employees may use PLOA due to the preparation for or attendance of a funeral for a family member. The length of time should be reasonable with the circumstances, at the staff member's discretion.

Vacation

This leave is available to our Exempt and Non-Exempt staff. Pro-rated benefits are provided to regularly scheduled; part-time employees based on the number of annual work hours.

Vacation Earnings Details

The following vacation schedule is followed by all regularly scheduled part time and full time employees. Any carryover balance in excess of the annual vacation earnings, if not used by June 30, will be deleted.

Earnings for Non-Exempt Staff		Earnings for Exempt Staff	
Years of Service	Vacation Weeks	Years of Service	Vacation Weeks
0 – 4	2 weeks	0 - 4	3 weeks
5 – 9	3 weeks	5 - 14	4 weeks
10 -14	4 weeks		
15 +	5 weeks	15 +	5 weeks

Full-time faculty are eligible for 20 days of vacation each fiscal year. Faculty issued a new contract of six months or less will be issued 10 days of vacation. Faculty vacation is not eligible for carryover or for payout.

Bridge:	The Bridge □ Administration □ Employee Handbook

Holidays Observed

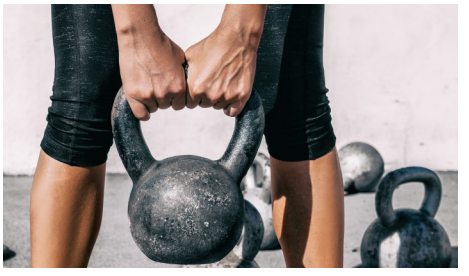
INDEPENDENCE DAY	CHRISTMAS DAY
LABOR DAY	NEW YEAR'S EVE
THANKSGIVING DAY	NEW YEAR'S DAY
DAY FOLLOWING THANKSGIVING	MEMORIAL DAY
CHRISTMAS EVE	FLOATING HOLIDAY\FLEXIBLE HOLIDAY

Other Services

Child Care Center

Employees interested in utilizing the Child Care Center should contact the Child Care center for more information. Childcare is available for children ages 2 and above. Regularly scheduled full and part-time employees may also be eligible for payroll deduction for childcare.

Contact:	Melissa Griffin | (920) 693-1243 | melissa.griffin@gotoltc.edu
Bridge:	The Bridge □ Instruction □ Child Care



Fitness Center

Employees may use the center's equipment which includes weight machines, rowing machines, bikes, tread mills and other workout equipment.

Contact Facilities or Student Services for more information

US Cellular Discount Program

Overview:

- The Partner Employee Discounts Program (PED Program) provides the employees of current U.S. Cellular® Business and Government accounts the opportunity to qualify for a discount on their wireless service.
- The discount will apply only to consumer (Individual Account Type) voice plans; discounts will not apply to any additional Vertical Services requested.

Verification Process:

- All validation will take place through an online e-mail verification platform at www.uscellular.com/partner, using the customer's corporate e-mail address.
- Employees may sign up at a US Cellular Retail Store.
- Required employment verification every 2 years.

Sports Core Discount

The Kohler Sports Core offers an employee discount for Lakeshore employees

Bridge:	The Bridge □ Administration □ Human Resources □ Benefits □ Miscellaneous

United Way

Lakeshore supports participation in the United Way (it is a form of fund solicitation for worthwhile community health and welfare organizations). If employees wish to contribute to United Way, they can make payments via payroll deduction, check, or credit card.

Tuition Reimbursement

Full time employees and part time employees scheduled a minimum of 1200 annual hours are eligible for tuition reimbursement after 12 months of employment. There is a $3,000 maximum reimbursement per fiscal year (July 1-June 30) and applicants must receive a grade of B or better. The Course Reimbursement Form should be completed, approved, and routed to Human Resources with a copy of the grade report or transcript. Note: Staff must maintain employment for two years after payment or repay the employee's reimbursement.

Contact:	Human Resources | 920-693-1863 | HumanResources@gotoltc.edu
Bridge:	The Bridge □ Administration □ Human Resources □ Forms Library

Retirement Plans

Wisconsin Retirement System (WRS)

The Wisconsin Retirement System provides a pension benefit to eligible employees. Membership is mandatory, under law, for staff employed full-time.

Eligibility

All Benefit Eligible employees who work at least one year and a minimum of 1,200* hours per year (880 for faculty) must contribute to WRS. The employee must earn five years of WRS-creditable service to be vested. One year of WRS-creditable service is equal to 1,320 hours for faculty and 1,904 hours for all others.

Contributions

The employee and Lakeshore each pay ½ of the total WRS required contribution (based on gross salary) for full-time staff. The deduction is pre-tax.

Contribution Rate – Changes Every year

2025- 14% Total (7% employer and 7% employee)

Employees who participated with WRS prior to July 1, 2011, and have not taken a separation benefit will be immediately vested upon hire if working a minimum of 600 hours per year or 440 for faculty.

Contact:	Department of Employee Trust Fund (ETF) | 877-533-5020 | www.etf.wi.gov
Bridge:	The Bridge □ Administration □ Human Resources □ Benefits □ (WRS & Retirement Savings)

Supplemental Retirement Options (403b & 457)

Lakeshore offers 403(b) and 457 plans to provide a convenient way to save for your future through payroll deductions.

Eligibility

You are eligible to participate in the plan as of your start date with Lakeshore or anytime thereafter.

Employee Contributions

Contributions from your pay are made on a pre-tax or post tax basis—up to the IRS annual limit. If you are 50 years of age or older, (or if you will reach age 50 by the end of the year), you may make a catch-up contribution in addition to the Normal IRS annual limit. There are no employer contributions. All employees are eligible for this benefit through payroll deduction. Participation must be in keeping with state and federal laws.

Maximum Contribution Limits – Changes every year

Maximum contributions for 2025 is $23,500. Over age 50 catch up is $7,500.

How to contribute to a 403b Plan

To make an elective contribution to the Plan, you must enroll with the 403b provider and submit a Salary Reduction Agreement to the Plan's Third-Party Administrator, TSA Consulting. You may make, change, or stop such an election to contribute at your discretion. The effective date of these changes will be the date listed on your Salary Reduction Agreement or the next payroll date after it is approved by TSA Consulting. For more information access the "Enrollment Kit TPA" located on: The Bridge □ Administration □ Human Resources □ Benefits (WRS & Retirement Savings)

How to contribute to a 457 Plan

Contact Wisconsin Deferred Compensation at 877-457-9327 or visit www.wdc457.org.

LAKESHORE COLLEGE

Retirement Plans

	Optional (No employer match)				Mandatory (If req met)
	Traditional 403(b)	Roth 403 (b)	457 Deferred Compensation	Roth 457 Deferred Compensation	Wisconsin Retirement System (WRS)
Contributions	Pre-Tax	After-Tax	Pre-Tax	After-Tax	Pre-Tax
Growth	Tax-Deferred	Tax-Free	Tax-Deferred	Tax-Free	
Distributions	Taxable Available at retirement and age 59 ½ Early withdrawals subject to 10% federal penalty	Taxable Available at retirement and age 59 ½ Early withdrawals subject to 10% federal penalty	Taxable -Available at separation of service No age requirement No 10% federal penalty on early withdrawals	Taxable -Available at separation of service No age requirement No 10% federal penalty on early withdrawals	Contribution rates determined by ETF. Employer Match Formula Based Annuity calculated at retirement. 5-year Vesting Rule for hires July 1, 2012, and after May participate in Variable Fund if desired. Minimum Retirement Age of 55 Employee share available for payout if term prior to age 55 Loans not available
Annual Maximum Contributions	$23,500 basic $7,500 extra if 50 years of age or over Contributions offset maximum Roth 403(b) Contributions	$23,500 basic $7,500 extra if 50 years of age or over Contributions offset maximum 403(b) contributions	$23,500 basic $7,500 extra if 50 years of age or over Contributions offset maximum Roth 457 contributions	$23,500 basic $7,500 extra if 50 years of age or over Contributions offset maximum 457 Contributions	
Loans	No	No	No	No	
Hardships	Yes, for most	Yes, for most	Yes	Yes	
Benefits	Reduces taxable income Provides tax-deferred income in retirement Can combine 403(b), 457 and Roth 457 plan contributions	Can combine 403 (b), 457 and Roth 457 plan contributions Tax-Free growth Provides tax free income in retirement	Reduces taxable income Provides penalty-free tax deferred income for those retiring before age 59 ½ Can combine 403(b), 457 and Roth 457 plan contributions	Tax Free growth Provides tax-free income in retirement Can combine 403(b), 457 and Roth 457 plan contributions	
Vendors	WEA Benefits 800-279-4030 www.weabenefits.com Fidelity Investments 800-343-0860 www.fidelity.com/atwork	WEA Benefits 800-279-4030 www.weabenefits.com Fidelity Investments 800-343-0860 www.fidelity.com/atwork	WDC (WI Deferred Comp) 877-457-9327 www.wdc457.org	WDC (WI Deferred Comp) 877-4457-9327 www.wdc457.org	ETF (Employee Trust Fund) 1-877-533-5020 www.etf.wi.gov

College Savings Plan

Edvest — Wisconsin's official 529 College Savings plan to help families save for higher education costs for their children. An Edvest plan is similar to 401k plans for retirement, but it's used to save for college.

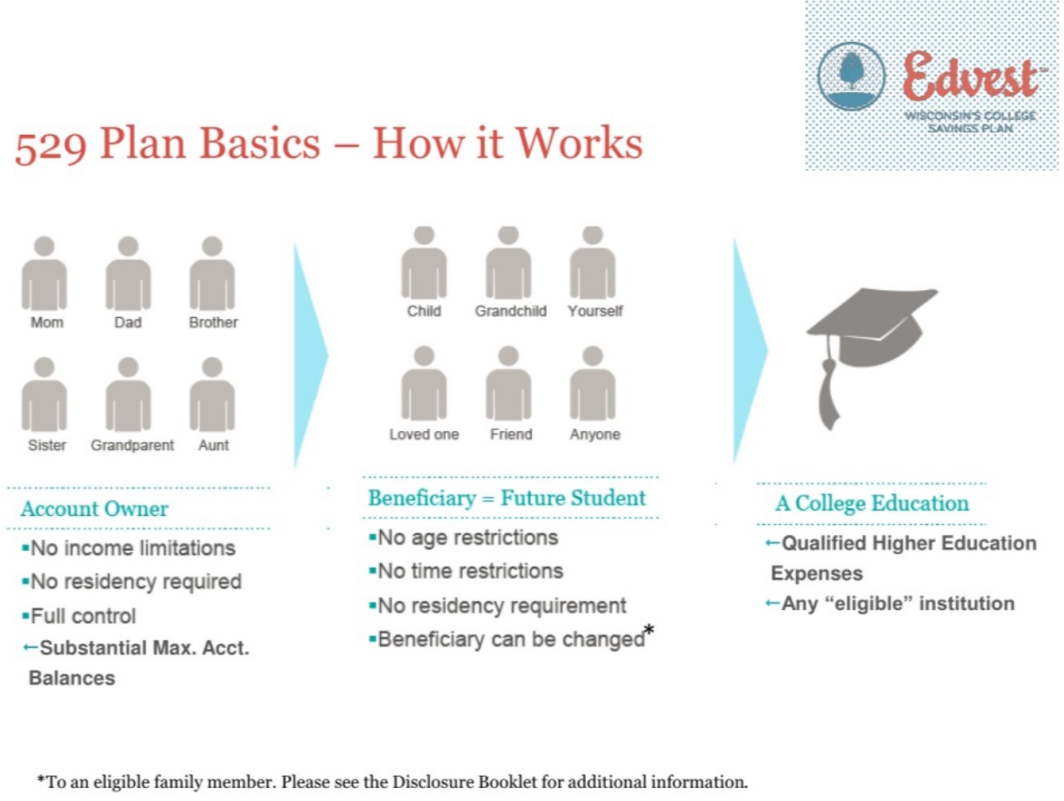
How to set up an account

There is a $25 contribution online – thereafter, Lakeshore offers payroll deduction with a minimum contribution of $15 per account each pay period. Edvest makes saving more affordable for more Wisconsin families.

Fast Facts

- Anyone may open or contribute to an Edvest Account, even out-of-state individuals.
- Wisconsin residents may be eligible for a state tax deduction (Limitations apply).
- Edvest funds may be used at universities, colleges, technical schools, graduate, and professional schools, as well as many certificate programs.
- Funds may be used at schools across the country and even some abroad.
- Use funds for tuition, books, room & board, computers, tablets & other expenses.
- Contribute whenever you want, at whatever amount you want, starting at $25 or $15 per pay period.
- Build savings by regularly contributing automatically through your bank account or payroll direct deposit.
- Opening an account takes about 15 minutes at edvest.com.

How it works



*To an eligible family member. Please see the Disclosure Booklet for additional information.

Contact:	Edvest | 888-338-3789 | www.edvest.com
Bridge:	The Bridge □ Administration □ Human Resources □ Benefits □ (Edvest 529 Education Savings Plans)

Resource Summary

There are many additional resources located on Lakeshore's Bridge website:

Bridge:	The Bridge Administration Human Resources Benefits

Resources include summaries of health, dental, and vision benefits, information about flexible spending and rollover, how to find providers, leave benefits and more.

About This Guide

This benefit guide provides selected highlights of the Lakeshore employee benefits program. It is not a legal document and shall not be construed as a guarantee of benefits nor of continued employment at the College. All benefit plans are governed by master policies, contracts, and plan documents.

Any discrepancies between information provided through this guide and the actual terms of the policies, contracts, and plan documents are governed by the terms of these policies, contracts, and plan documents. Lakeshore College reserves the right to amend, suspend or terminate any benefit plan, in whole or in part, at any time. The Plan Administrator has the authority to make these changes.

Employee Premiums

2025

Benefit Rates

Benefit Rate Comparison

UMR—Health
Delta Dental—Dental
Symetra—Life
Superior Vision—Vision
Wex—COBRA

HEALTH		2025		
		Full Premium	Employee 20%	Employer 80%
Active and Early Retirees	Single	$847.33	$169.46	$677.87
	Family	$2,526.45	$505.29	$2,021.16
	Family + Spousal Surcharge		$605.29	
	Employee + Spouse	$1,854.80	$370.96	$1,483.84
	Employee + Spouse + Surcharge		$470.96	
	Employee + Children	$1,518.99	$303.80	$1,245.57
	Special Medicare Retiree + Spouse	$1,719.36	$343.87	$1,375.49
	Special Medicare Family	$2,391.01	$478.20	$1,912.81

DENTAL		2025		
		Full Premium	Employee 14%	Employer 86%
Active and Early Retirees	Employee Only	$46.27	$6.48	$39.79
	Family	$132.87	$18.60	$114.27

VISION Exam & Materials Plan		2025		
		Full Premium	Employee 100%	Employer 0%
Active and Early Retirees	Employee Only	$7.64	$7.64	$0.00
	Employee + Spouse	$15.28	$15.28	$0.00
	Employee + Child(ren)	$17.26	$17.26	$0.00
	Family	$26.69	$26.69	$0.00

VISION Materials Only Plan		2025		
		Full Premium	Employee 100%	Employer 0%
Active and Early Retirees	Employee Only	$5.61	$5.61	$0.00
	Employee + Spouse	$11.22	$11.22	$0.00
	Employee + Child(ren)	$12.43	$12.43	$0.00
	Family	$19.31	$19.31	$0.00

LAKESHORE COLLEGE

Contact Information

Plan	Contact	Phone Number	Website/Email
Health Insurance Group # 76-412171	UMR Medical, Network Providers, HRA, & Claims	800-826-9781	www.umr.com
	UMR Care Management	866-494-4502	
	To Order a New Card	800-320-3206	
	Username/Password/Technical Assistance	866-922-8266	
Other Insurance Information	UMR	800-826-9781	www.umr.com
Prescription Drugs	Optum	800-356-3477	https://welcome.optumrx.com/standard/getstarted
Flexible Spending	Associated Bank	800-236-8866	www.associatedbank.com
Weight Management Program	Real Appeal (Part of Lakeshore's health insurance)	844-344-7325	we.realappeal.com support@realappeal.com
Telemedicine	Teladoc	800-835-2362	www.Teladoc.com
Dental Plan	Delta Dental	800-236-3712	www.deltadentalwi.com
Vision Insurance	Superior Vision	800.923.6766	www.superiorvision.com
COBRA	Discovery Benefits/WEX	866-451-3399	www.discoverybenefits.com
Vision Discount	EyeMed Vision Care	866-246-9041	www.deltadentalwi.com/providersearch/vision/
HOPELINE™	HOPELINE Center for Suicide Awareness	Text: HOPELINE To 741741	www.centerforsuicideawareness.org/hopeline/
Mental Health	Mental Health America	800-273-8255	www.mentalhealthamerica.net
Employee Assistance Programs (EAP)	National Insurance Services	866-451-5465	www.niseap.com
			Login: NISEAP I Password EAP (Note: Password is case-sensitive)
Life & AD&D Insurance	Lakeshore Human Resources Department	920-693-1163	Debbie.Sosnosky@gotoltc.edu
Long-Term Disability Insurance	Lakeshore Human Resources Department	920-693-1163	Debbie.Sosnosky@gotoltc.edu
Edvest - Wisconsin's 529 College Savings Plan	Edvest College Savings Plan	888-338-3789	www.edvest.com
Wisconsin Retirement System (WRS)	ETF-Department of Employee Trust Funds	877-533-5020	www.etf.wi.gov

Contact Information

Plan	Contact	Phone Number	Website/Email
457 Deferred Compensation Plan	Wisconsin Deferred Comp	877-457-9327	www.wdc457.org
403(b) Retirement Savings Plans	TSA Consulting Third Party Administrator (TPA) of 403b plans	888-796-3786, Option 5 Fax: 866-908-7582	www.tsacg.com
	WEA Benefits	800-279-4030	www.weabenefits.com
	Fidelity Investments (7am-11pm CST)	800-343-0860 / 800-328-6608	www.fidelity.com/atwork

Human Resources Contact Information

Contact	Area	Phone Number	Email
Marissa Holst	Executive Director of Human Resources	920-693-1139	Marissa.Holst@gotoltc.edu
Debbie Sosnosky	Manager of Benefits & Human Resources	920-693-1163	Debbie.Sosnosky@gotoltc.edu
Kim Schad	Payroll Services Manager	920-693-1869	Kim.Schad@gotoltc.edu
Lisa Kwarciany	Human Resources Specialist	920-693-1158	Lisa.Kwarciany@gotoltc.edu
Matt Pahmeier	Talent Acquisition Coordinator	920-693-1860	Matt.Pahmeier@gotoltc.edu

Important Notices

Newborn & Mother's Health Protection Act Notice

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 the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Women's Health & Cancer Rights Act Enrollment Notice

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

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

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. If you would like more information on WHCRA benefits, contact Human Resources.

HIPPA Notice of Privacy Practices Reminder

The organization is committed to the privacy of your health information. The administrators of the medical 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 Notice of Special Enrollment Rights

If you are eligible to participate in the benefit plans, you must complete the required enrollment steps and pay a part of the premium through payroll deductions, if applicable. 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.

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, 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).

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.

In addition, 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 dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

To request special enrollment or obtain more information, contact Human Resources.

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 July 31, 2024. Contact your State for more information on eligibility –

ALABAMA – Medicaid	CALIFORNIA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	Website: Health Insurance Premium Payment (HIPP) Program http://dhcs.ca.gov/hipp Phone: 916-445-8322 Fax: 916-440-5676 Email: hipp@dhcs.ca.gov
ALASKA – Medicaid	**COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)**
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	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 711Health Insurance Buy-In Program (HIBI): https://www.colorado.gov/pacific/hcpf/health-insurance-buy-program HIBI Customer Service: 1-855-692-6442
ARKANSAS – Medicaid	**FLORIDA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268
GEORGIA – Medicaid	**MAINE – 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	Enrollment Website: 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

Important Notices

INDIANA – Medicaid	MASSACHUSETTS – Medicaid and CHIP
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	Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840
IOWA – Medicaid and CHIP (Hawki)	**MINNESOTA – Medicaid**
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	Website: 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
KANSAS – Medicaid	**MISSOURI – Medicaid**
Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005
KENTUCKY – Medicaid	**MONTANA – 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	Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084
LOUISIANA – Medicaid	**NEBRASKA – 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)	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
NEVADA – Medicaid	**SOUTH CAROLINA – Medicaid**
Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	Website: https://www.scdhhs.gov Phone: 1-888-549-0820
NEW HAMPSHIRE – Medicaid	**SOUTH DAKOTA - 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	Website: http://dss.sd.gov Phone: 1-888-828-0059
NEW JERSEY – Medicaid and CHIP	**TEXAS – Medicaid**
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	Website: http://gethipptexas.com/ Phone: 1-800-440-0493

Important Notices

NEW YORK – Medicaid	UTAH – Medicaid and CHIP
Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831	Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
NORTH CAROLINA – Medicaid	**VERMONT– Medicaid**
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427
NORTH DAKOTA – Medicaid	**VIRGINIA – Medicaid and CHIP**
Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825	Website: https://www.coverva.org/en/famis-select https://www.coverva.org/en/hipp Medicaid Phone: 1-800-432-5924 CHIP Phone: 1-800-432-5924
OKLAHOMA – Medicaid and CHIP	**WASHINGTON – Medicaid**
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022
OREGON – Medicaid	**WEST VIRGINIA – Medicaid and CHIP**
Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075	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)
PENNSYLVANIA – Medicaid	**WISCONSIN – Medicaid and CHIP**
Website: https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx Phone: 1-800-692-7462	Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002
RHODE ISLAND – Medicaid and CHIP	**WYOMING – Medicaid**
Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)	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 July 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 1/31/2023)

Notice of Creditable Coverage — 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 and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

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

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

2. Your employer 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.

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 through the company 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 your Human Resources or benefits representative 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 the company 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).

Date:	**January 01, 2025**
Name of Entity/Sender:	**Lakeshore College**
Contact—Position/Office:	**Debbie Sosnosky—Manager of Benefits & Human Resources**
Office Address:	**1290 North Avenue** **Cleveland, Wisconsin 53015-1412**
Phone Number:	**920-693-1163**

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).

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.

Marketplace Notice

New Health Insurance Marketplace Coverage Options and Your Health Coverage

PART A: General Information

Even if you are offered health coverage through your employment, you may have other coverage options through the Health Insurance Marketplace ("Marketplace"). To assist you as you evaluate options for you and your family, this notice provides some basic information about the Health Insurance Marketplace and health coverage offered through your employment.

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 in your geographic area.

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

You may qualify to save money and lower your monthly premium and other out-of-pocket costs, but only if your employer does not offer coverage, or offers coverage that is not considered affordable for you and doesn't meet certain minimum value standards (discussed below). The savings that you're eligible for depends on your household income. You may also be eligible for a tax credit that lowers your costs.

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%[1] 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]

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.

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

[1]Indexed annually; see https://www.irs.gov/pub/irs-drop/rp-22-34.pdf for 2023.

[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.

** Continuation Coverage Rights Under COBRA**

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 the Plan Administrator.

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 period1 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.

If you have questions

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

Keep your Plan 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.

Notes

This benefit summary prepared by

Gallagher

Insurance | Risk Management | Consulting