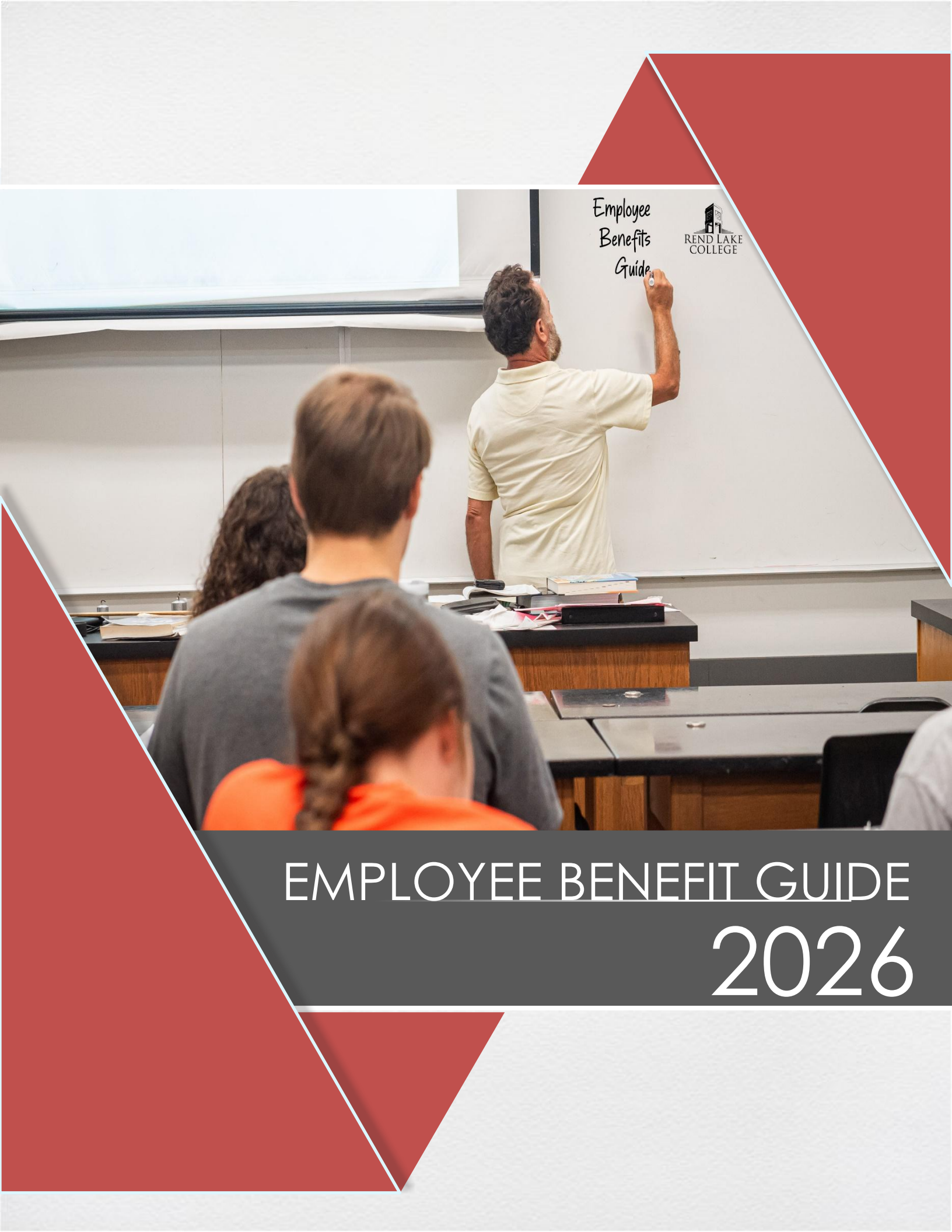




Employee
Benefits
Guide



EMPLOYEE BENEFIT GUIDE 2026

Eligibility

At Rend Lake College, we strive to provide the most comprehensive and affordable benefits package for our most valuable assets, you the employee. We understand how costly benefits can be and the strain it can cause on you and your families. That is why we, as your employer, have chosen not only offer benefits, but to contribute to the cost as well.

Rend Lake College offers Medical, Dental, and Vision Benefits as an all-inclusive package. This means that you will be enrolled in all 3 benefits should you elect to join the Rend Lake benefit plan.

Who is Eligible?

Employees who work a minimum of 30 hours a week and their dependents are eligible to enroll in the benefits.

When are you eligible for benefits?

Employees are eligible for benefits for themselves and their dependents on their Date of Hire.

When will you enroll in benefits?

All employees will have the opportunity to enroll in benefits during Annual Open Enrollment (if not a newly hired employee). At this time, employees may enroll in new benefits and/or make and changes to their current benefit elections.

What if you need to make a benefit change outside of open enrollment?

Employees may make off cycle changes to their benefits if there is a Qualified Event. This change must be made within 30 days of the event, and it is the employee's responsibility to notifying their employer.

What if I leave Rend Lake College?

Benefits will end at the end of the terminating month.

Qualifying Events

- Marriage
- Divorce
- Legal Separation
- Birth or Adoption of a Child
- Change in Dependent Status
- Change in residence due to employment
- Job Transfer for Employee or their Spouse
- Change in spouses' benefits
- Change in employments status



Rend Lake College offers a comprehensive health care program to meet the needs of you and your family. Your medical plan is administered by PBA, using Health link Network. The Prescription drug coverage is administered by TrueRx. Your medical plan details are outlined below. Please note- See Summary of Benefit Coverage for information on Out of Network coverage

By visiting www.pbaclaims.com, you can set up your member portal to access claims payment information, request ID cards, and a list of other useful features to help you manage your medical benefits.

Please note this is a summary of the plans offered, please contact your employer if you would like full plan details.

Please Note:

IRS has released their inflation adjustment amounts for 2026 relevant to health savings accounts and embedded high-deductible plans. Due to this required adjustment, there was an increase to the **deductible amounts** for your 2026 Medical Plan.

All benefits go into effect 7/1/2026

In-Network Plan Benefits	HDHP
Individual/Family Deductible	\$3,400/\$6,800
Individual/Family Out of Pocket Maximum	\$6,450/\$12,900
Coinsurance	Plan pays 100% after Deductible
Primary Care Physician/Specialist	Plan pays 100% After Deductible
Urgent Care	Plan pays 100% After Deductible
Inpatient Hospital/ Outpatient	Plan pays 100% After Deductible
Emergency Room	Plan pays 100% After Deductible
Pharmacy Benefits: Copayments apply AFTER the Plan Year Deductibles have been met	
Tier 1: Generic Retail/Mail Order	\$15 Copay Retail/\$37.50 Mail Order
Tier 2 Preferred Retail/ Mail Order	\$30 Copay Retail/\$75 Copay Mail Order
Tier 3 Non-Preferred/ Retail/ Mail Order	\$30 Copay Retail/\$75 Copay Mail Order
Specialty	Covered

*See Certificate of Coverage for details on limits, and exclusions.

Health Savings Account

What is a Health Savings Account?

Otherwise known as an HSA, a health savings account can be funded with pre-tax dollars, by the employer or employee. Funds from the account can help pay for qualified medical, dental or vision expenses not paid by an insurance plan, including the deductible and coinsurance.

Who is not eligible to open and contribute to an HSA Bank Account?

- Employees who are enrolled in Medicare Part A
- If you or your spouse are enrolled in a regular medical FSA-limited FSA enrollment is okay.
- Anyone who has dual coverage (HSA participant covered by another plan not HSA compatible)
- Employees who are receiving Tri-Care or VA Benefits

2025 Maximum HSA Contribution Limit? (Employee)

- \$4,300 for individual coverage
- \$8,550 for family coverage
- Individuals aged 55 or older are eligible to make a catch-up contribution of \$1,000
- These amounts may be prorated if you are on the plan for less than 12 months

Commonly Asked Questions & Answers:

What expenses are eligible for reimbursement for my HSA?

HSA dollars may be used for qualified medical, dental and vision expenses incurred by the account holder and his or her spouse and dependents. Qualified medical expenses are outline within IRS Section 213 (d). In summary, the IRS Section 213 (d) states that “*the expense has to be primarily for the prevention or alleviation of a physical or mental defect or illness.*”

What happens when my HSA funds run out?

You may be financially responsible for any eligible medical expenses that fall within the coverage gap.

Can I use my HSA dollars for non-eligible expenses?

Money withdrawn from an HSA account to reimburse non-eligible medical expenses is taxable income to the account holder and is subject to a 20% tax penalty-unless over age 65, disabled or upon death of the account holder.

When can I start using my HSA dollars?

You can use your HSA dollars immediately following your HSA account activation and once contributions have been made.

What if I have HSA dollars left in my account at year-end?

The money is yours to keep. It will continue to earn interest and will be available for you and your health care costs next year.



PBA ID Card Sample

Make sure your providers have a copy of your current ID card at all times.

Your ID card gives your providers the key information to properly submit claims directly to PBA.

*initial set of 2026 ID cards will be sent to Rend Lake College.

Eligibility Details:

Your name, group number, and identification number

Pharmacy Prescription information

provides your pharmacist the necessary information to run your prescription under the plan

Claim Filing Instructions:

Where to send your claim electronically or manually

PPO Information to provide a quick reference to see if your provider is in network

Member Advocacy information: Who to call to verify Eligibility & Benefits – 800.435.5694

Pre-certification Information: Who to call to avoid penalties if admitted to hospital

The image shows a sample PBA ID card with the following sections:

- Header:** PBA Professional Benefit Administrators, Inc. Questions? 800.435.5694 www.pbaclaims.com. A red "RED" label is in the top right corner.
- Member Information:**
 - Employer: ABC Company, Inc.
 - Group #: SAMPLE
 - Member: JOHN SAMPLE
 - Member ID: SMPL0001
- Medical Plan:**
 - Effective: [blank]
 - Coverage: [blank] **YourPPO**
 - Copays: PPO Office Visit \$20
- Ancillary Plan(s):**
 - Dental Plan:** Effective: [blank], Coverage: [blank]
 - Vision Plan:** [blank]
- Pharmacy Plan:**
 - Rx Bin: 90909
 - PCN: YPBM
 - Rx Group: 1234
 - YourPBM**
 - www.yourpbm.com
 - Member: 800.123.4567
 - Pharmacy: 888.765.4321
- Medical Claims Submission:**
 - EDI: Payer ID 36331
 - Mail: Professional Benefit Administrators, Inc., PO Box 4687, Oak Brook, IL 60522-4687
 - 800.435.5694
 - www.pbaclaims.com
- Dental/Vision Claims Submission:**
 - EDI: Payer ID 36331
 - Mail: Professional Benefit Administrators, Inc., PO Box 4687, Oak Brook, IL 60522-4687
 - 800.435.5694
 - www.pbaclaims.com
- Eligibility:**
 - To confirm eligibility and/or obtain benefit determinations, please call PBA at 800.435.5694.
 - This card is not a guarantee that coverage is in effect.
- Pre-Certification:**
 - Utilization Review Inpatient Pre-Admission Cert.**
 - Pre-Certification is required for any non-urgent inpatient confinement or any outpatient surgery. Urgent Care confinements must call within 48 hours. Failure to make this call will reduce your benefits.
 - For Pre-Certification, or Pre-Authorization, call (UR V. XXX.XXX.XXXX).

To download an electronic version of your ID card, login to your account at www.pbaclaims.com. If you need to order new ID cards, please visit www.pbaclaims.com or contact our Member Advocacy Department at 800.435.5694.

Mobile Benefits Portal



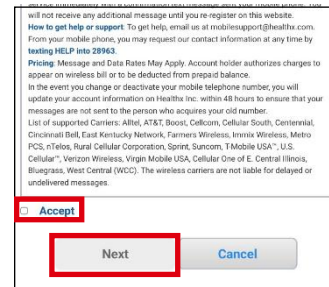
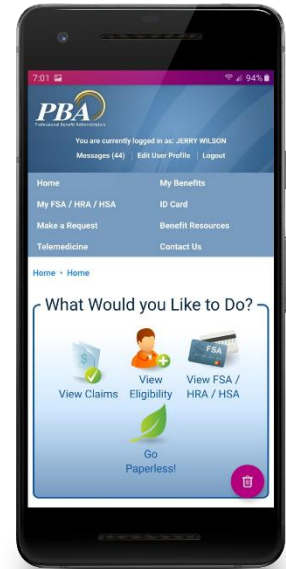
Access Mobile Benefit Information 24/7/365

PBA's member benefits portal website offers you a robust suite of mobile tools with which you can manage your benefits. With the mobile benefits portal you can:

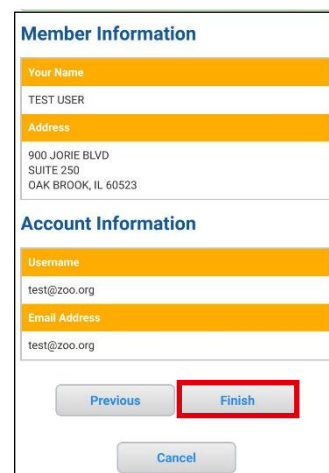
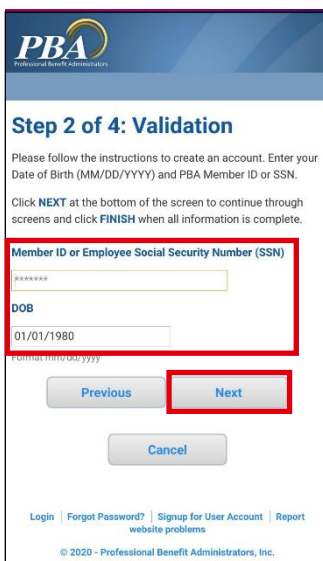
- View your virtual ID card
- Download electronic EOBs
- Access a link to the provider search page for your plan
- View current coverage and enrollment information
- Download your plan document, SBC, and benefit forms.
- Get answers with FAQs or communicate securely with PBA customer service

Access the Mobile Benefit Portal - New Users

1. Go to pbaclaims.com and touch **Secure Login > Employee**.
2. Click **Create a new account**.
3. Check **Accept** and click **Next** if you agree to the terms and conditions.



4. Enter the employee Social Security Number (SSN) and employee date of birth. Touch **Next**.
5. Enter your email, which will be your username, create your password, and setup your security questions and answers. Touch **Next**.
6. Verify your information and touch **Finish**.



If You Have an Existing Account

1. Go to pbaclaims.com and touch **Secure Login > Employee**.
2. Enter your username and password then touch **Login**.

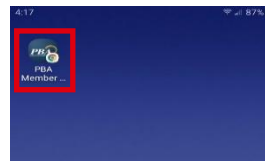
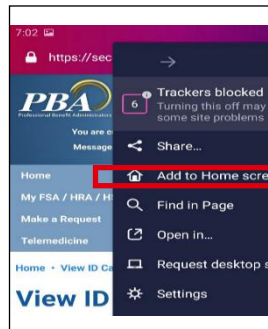


Add the Benefits Portal to Your Mobile Home Screen

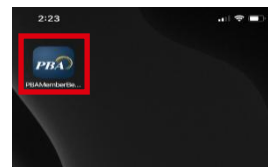
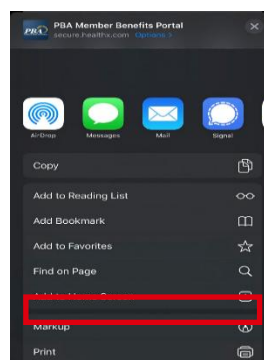
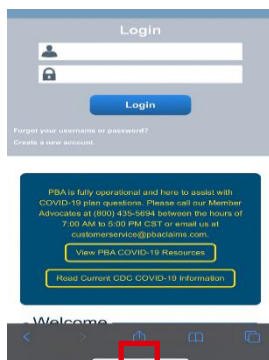
The PBA benefits portal can be added to your device's home screen. Once added to your home screen you can launch the web portal with a tap. Follow these instructions to add the benefits portal to your home screen:

Go to the PBA benefits portal on your mobile device using the mobile web browser of your choice

On Android devices, touch the bookmark button then touch **Add to Home Screen**.



On iOS devices, open the browser menu, touch the share icon, then touch **Add to Home Screen**.



800.435.5694 | pbaclaims.com |

[Health Care Tools & Resources for Members | HealthLink](#)
[Find A Doctor Near You | HealthLink](#)

How to Read Your Claim Summary

This sample statement will show you where to look for information when your claims are processed. You will receive a Claim Summary that includes all family members during the noted period.

You can see your weekly claims activity on our website by logging into your benefits portal website account at pbaclaims.com.

- 1 PBA contact information appears here. If you have any questions regarding your Claim Summary, please have your user ID number and claim number available when you call.
- 2 Your name and address will appear here.
- 3 Your group number, group name, and check generation date will appear here.
- 4 **For the Period:** Shows the period that claims were incurred.
- 5 **Date(s) of Service:** The date the services were incurred.
- 6 **Type of Service:** The type of service performed by your provider (office visit, lab, x-ray, etc.)
- 7 **Total Charge:** The total amount charged by the provider.
- 8 **Ineligible Amount:** Any amount not covered by the plan. Ineligible Amount will be further explained with a reason code description in section 18 and may be included in the amount you may owe.
- 9 **Reason Code:** Reflects any comments about why a service may not have been covered or any other important information.
- 10 **Discount Amount:** The savings amount applied to this claim will be reflected here. The patient is not responsible for this amount.
- 11 **Covered by Plan:** The new allowed amount of the claim after the ineligible and discount amounts are applied.
- 12 **Deductible Amount:** This reflects how much of the claim will be applied to your deductible.
- 13 **Co-Pay Amount:** This reflects the amount you will be responsible for as defined by your plan.
- 14 **Balance Amount:** The amount after all deductions (ineligible, discount, deductible, and co-pay amounts) are applied.
- 15 **Paid At:** The percentage of benefit paid by the plan.
- 16 **Payment Amount:** Reflects the total benefit that was paid by the plan.
- 17 **Patient's Responsibility:** Any amount you may be responsible for will appear here (deductible, coinsurance, copayments or services that are not covered).

Page 1 of 2

068 [51] 1 of 1

PBA Professional Benefit Administrators
PO Box 4687
Oak Brook, IL 60522-4687

Explanation of Benefits
RETAIN FOR TAX PURPOSES
THIS IS NOT A BILL

Customer Service

1 If you have questions or need an explanation of this form, contact Customer Service at (800) 435-5694 www.pbaclaims.com

3 Group: 098501 - ABC COMPANY
Date: 5/21/2013

Forwarding Service Requested

2 *****51 1 SP 0-460
DONALD ABBOTT
123 ANYSTREET
OAK BROOK, IL 60523

For the Period: 04/01/2013 through 04/22/2013

Dear DONALD ABBOTT,

The information below is a summary of your healthcare claims for the period referenced above. This information is commonly referred to as an "Explanation of Benefits" (EOB). This is a summary, followed by the claim details, of how your recent claims were processed. It includes any co-pay, deductible, coinsurance (%) or non-covered amounts that you may owe to the pr

Total Amount Billed
\$224.95
This is the total amount for bills received for the dates of service 04/01/2013 through 04/22/2013

Total Amount Paid By Plan
\$68.00
This is the amount the plan paid for services billed. Please see the claim detail section below for more information.

Your Financial Responsibility
\$37.00
This is the amount the provider of service may bill you after your health plan benefits were paid. Typically a plan participant may be billed by the provider of service because they may have a deductible, co-pay, coinsurance (%), or the service is not covered by the health plan. A breakdown of your total financial responsibility is shown in the claim detail for each member.

Claim#	6	23123456	7	8	9	10	11	12	13	14	15	16
Patient:	6	ALD ABBOTT	7	8	9	10	11	12	13	14	15	16
Dates of Service	Type of Service	Total Charge	Ineligible Amount	Reason Code	Discount Amount	Covered By Plan	Deductible Amount	Co-pay Amount	Balance Amount	Paid At	Payment Amount	
04/01/2013	SUPPLIES	\$55.00	\$55.00	10	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	0%	\$0.00	
04/01/2013	SUPPLIES	\$19.95	\$19.95	10	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	0%	\$0.00	
Column Totals		\$74.95	\$74.95		\$0.00	\$0.00	\$0.00	\$0.00	\$0.00		\$0.00	
Patient's Responsibility:		\$0.00										
Other Credits or Adjustments												
Total Net Payment		\$0.00										

Claim#	123123457	Provider	FAMILY CHIROPRACTIC	Employee	DONALD ABBOTT						
Patient:	ABBY ABBOTT	Pat#:	123456	Network:	N/A						
Dates of Service	Type of Service	Total Charge	Ineligible Amount	Reason Code	Discount Amount	Covered By Plan	Deductible Amount	Co-pay Amount	Balance Amount	Paid At	Payment Amount
04/22-04/22/2013	OV SERVICES	\$150.00	\$0.00		\$45.00	\$105.00	\$0.00	\$20.00	\$85.00	80%	\$68.00
Column Totals		\$150.00	\$0.00		\$45.00	\$105.00	\$0.00	\$20.00	\$85.00		\$68.00
Patient's Responsibility:		\$37.00									
Other Credits or Adjustments											
Total Net Payment		\$68.00									

Powered by People



Driven by Results

18 Reason Code Description: Reflects any comments about why a service may not have been covered or any other important information.

19 Payment Details: Reflects who received a benefit payment for this claim.

20 Plan Status: Reflects your deductible, and out-of-pocket amounts remaining as defined by your plan.

21 You Should Know: Special reminders and announcements appear here.

Page 2 of 2

18 Reason Code Description

10	DUPLICATE OF CHARGES PREVIOUSLY CONSIDERED
----	--

19 Payment Details

Paid To	Check Date	Check No.	Amount
DONALD ABBOTT	05/21/13	29555	\$68.00

20 Plan Status

These totals are accurate as of the last claim shown on this document. If you received care more recently, unprocessed claims for that care will not yet be reflected in the totals shown here.

Accumulators	Amount Remaining
Ind. Deductible	\$0.00
Fam. Deductible	\$0.00
Ind. Coinsurance	\$233.68
Fam. Coinsurance	\$0.00

21 You Should Know

Are you tired of receiving paper statements? **View & Print Statements online.** Go to www.pbaclaims.com, click on the employee tab to create your own account, and go paperless!

Powered by People

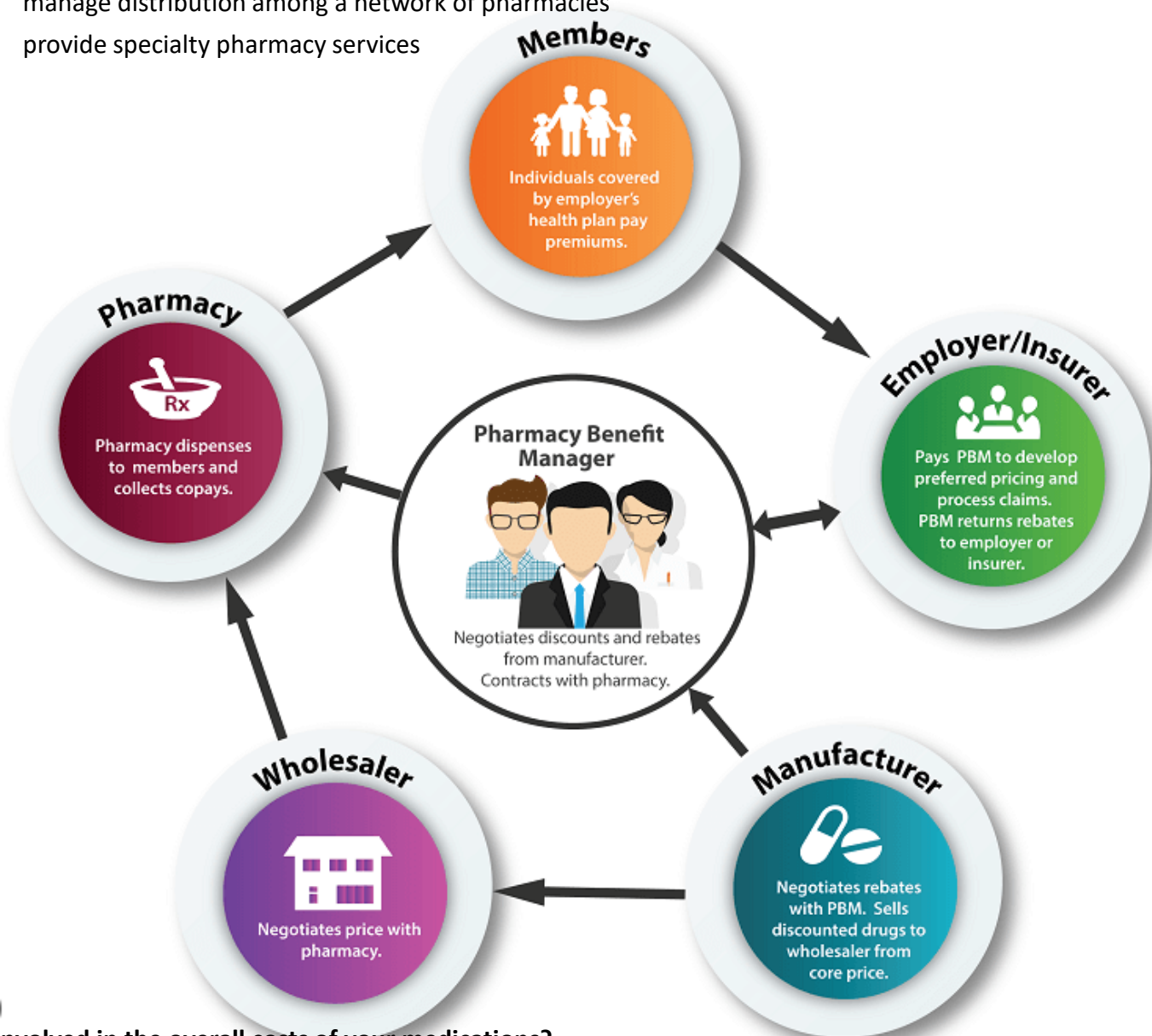


Driven by Results

•
Who is TrueRx? TrueRx is your groups' Pharmacy Benefit Manager (PBM). A Pharmacy Benefit Manager, or PBM, is an organization that provides programs and services designed to help maximize drug effectiveness and contain drug expenditures by appropriately influencing the behaviors of prescribing physicians, pharmacists, and members.

A PBM is Responsible for:

- negotiate rebates
- operate mail order
- oversee patient compliance
- perform drug utilization reviews
- process claims
- maintain formularies
- manage distribution among a network of pharmacies
- provide specialty pharmacy services



Who is involved in the overall costs of your medications?

1. **Drug Manufacturers** – They negotiate rebates with PBMs and sell discounted drugs to wholesalers from their core price.
2. **Wholesalers:** Negotiate the costs of medications with pharmacies
3. **Pharmacies:** Negotiate prices with drug manufacturers and wholesalers which can result in different costs for the same medication and different pharmacies. –Operating Costs at pharmacies can influence drug pricing (salaries, rent utilities etc.) Pharmacies set their own profit margins, and dispensing fees.

Pharmacy Benefit Information



HELLO

Welcome to Your Pharmacy Benefits

We understand that managing your health isn't always simple. We're in your corner, helping you access affordable medications with genuine care.



Within this Welcome Kit:

In this welcome kit, you will find essential topics and resources to help you navigate and make the most of your pharmacy benefits.

pg 2 Next Steps for Your Pharmacy Benefits

Guidance on how to get started with your pharmacy benefits, including important actions to take.

pg 3 Answers to Frequently Asked Questions

Commonly asked questions and their answers to help you better understand your pharmacy benefits.

pg 4 How to Access Your Benefits

Step-by-step instructions on how to download our mobile app, True Rx+, in your app store or use the member portal.

pg 5 Mail Order Options

Skip the pharmacy line and have your medication delivered.



Experience the
HEALTH STRATEGISTS
Difference

You're More Than a Member Number. You Are *Our Patient*.

Your well-being is our priority, and we are here to support you every step of the way.

Live representatives answer your call

Our Patient Experience representatives are specially trained to address your pharmacy benefit questions.

Support for specialty medications

Dedicated care managers and clinical pharmacists are highly experienced in addressing the complexities and costs of specialty medications providing you with personalized care.

Manage your benefits anywhere with the True Rx+ mobile app

Access your insurance card and plan details, compare medication prices at local pharmacies, chat with a live True Rx Health Strategist, and more.

Next Steps

01

Watch for your new insurance card and bring it with you to the pharmacy.

02

Download True Rx+ in your app store or use the member portal at "member.myplantruerx.com" .



Frequently Asked Questions



How much will my medication cost?

To view the closest estimate of the amount you would pay for a medication, use the price check tool in the “Savings Center” in the True Rx+ app or member portal.

What should I do if my medication is delayed or denied?

The primary reason a prescription is delayed or denied is that the pharmacy lacks necessary insurance information from your new ID card. Be sure to give the pharmacy your updated information. If you have questions, give us a call or chat with us through the True Rx+ app. Our Patient Care team would be happy to help.

What should I do if I need a Prior Authorization?

Some medications require a prior authorization (PA). This means your provider must submit documentation showing the medication is safe, effective, and meets certain criteria set by your plan and FDA regulations. Your medication will only be covered once True Rx approves the PA.

You can check the status of your PA in the True Rx+ app and member portal.

I take a specialty medication. What should I do?

You have access to a dedicated specialty care manager to help address any questions you may have. Please give us a call and we would be happy to assist you.

Call Our Patient Care Team

Live representatives answer your call
Monday – Friday 8am to 8pm ET.

 **866-921-4047**



Kyra, Patient Care Manager



Manage Your Pharmacy Benefits *Anytime, Anywhere*



Say *hello* to True Rx+, an Enhanced App and Portal

True Rx+ is more than just a pharmacy app. It's your personalized digital pharmacy experience designed to help you stay informed, save money, and get support when you need it the most.

What You Can Do With True Rx+



View your
insurance card and
plan details



See your active
prescriptions, deductible,
and out-of-pocket status



Compare
medication prices
at local pharmacies



Track prior authorizations
in real time



Set refill
reminders



Chat with a live True Rx
Health Strategist

Download True Rx+ *today!*





Medication Delivered to Your Door

Skip the pharmacy line and receive personalized care.

True Rx Health Strategists partners with WB Rx Express to deliver your prescriptions right to your door. With WB Rx Express, you can manage, refill, and get information about your medications with ease, while receiving exceptional service.

Like True Rx, WB Rx Express is a family-run pharmacy serving communities for decades. It's the place to go if you want personalized and friendly service that is convenient and accessible.

Zero hassles—WB Rx Express makes medication easy

WB Rx Express offers options to simplify your medication management:

- ✓ ***Never miss a dose with WB DosePak!***
Pharmacists sort your medications by day and time, making it easier for you take them exactly as prescribed.
- ✓ ***Synchronized refills***
Sync your medication fills to get them all at once.
- ✓ ***Prescription autofill***
Refills are automatically shipped before you run out.

Did You Know?

By ordering a mail order 90-day supply, stock up and enjoy savings for months to come.

- **98% PATIENT SATISFACTION**
- **99.8% QUESTIONS RESOLVED IN ONE CALL**
- **5 SECOND AVERAGE TIME TO ANSWER**
- **PRESCRIPTIONS SHIPPED IN 24 HOURS***

*Average turnaround time



Get Started in Three Easy Steps

step
01

Go to wbrxexpress.com and click "Become a New Patient".

step
02

Complete the online form and click the red "Submit" button.

You can also set up your account by calling the pharmacy at 833-391-0126.

step
03

WB Rx Express will contact you within two business days to verify your account and medication information.

Kindly inform us at least 14 days in advance if you need a refill or wish to cancel your automatic refill.

Mail Order Medication Prices in the Member Portal

Mail order pricing is integrated with the True Rx+ app and member portal, member.myplantruerox.com. Compare mail order pricing with retail pharmacies in your area.

Payment Options

WB Rx Express accepts MasterCard, Visa, Discover, and American Express.

Limitations of Mail Order

- Please use your local pharmacy for a 30-day or less supply of medication.
- Refill orders submitted prematurely may be delayed until the earliest allowable date for processing.
- For your safety, WB Rx Express does not dispense Schedule II controlled substances.



Low-Cost Medication with Personalized Care

Mark Cuban Cost Plus Drugs is an in-network mail order pharmacy for patients

True Rx Health Strategists has teamed with Mark Cuban Cost Plus Drug Company to provide you with another easy option to get low-cost medications. You can choose to purchase your medications directly through the Cost Plus Drugs website, costplusdrugs.com. You may also access the Cost Plus Drugs website through the True Rx+ app or member portal, member.myplantruerox.com.

Medications ordered through Cost Plus Drugs will be considered in-network for your insurance plan.

- ✓ The cost of your medication will apply toward your insurance deductibles and out-of-pocket maximums.
- ✓ Your co-pay will be applied following your pharmacy benefit plan guidelines.
- ✓ You can rely on the True Rx Patient Care team for help with your pharmacy benefit questions.

It's Easy to Get Started with Cost Plus Drugs

step **01**

Check to see if your medication is available

- Visit CostPlusDrugs.com and click see all medications.
- If you see your medication, follow the steps to create an account.

step **02**

Create your account

- Enter your basic health information, your True Rx pharmacy insurance card information, and your health care provider information.

step **03**

Ask your doctor to send prescriptions to Cost Plus Drugs

- Click how to contact your doctor for information to help when asking your doctor to send in your prescription.

step **04**

Look for your confirmation email and complete your medication order

- You will receive an email from Cost Plus Drugs when they receive your prescription.
- Be sure to check request insurance price to have your prescription process with your True Rx insurance.
- Enter your shipping address and payment information.
- Your medication will be shipped to your doorstep.



ATTACK PRESCRIPTION SPEND

INTRODUCING THE SHARX PROGRAM

High-Cost
Prescription Access

Your employer will begin providing a new service to enrolled members in your current health plan. It's a prescription drug benefit and advocacy program provided through SHARx.



What is SHARx?

SHARx is an advocacy solution provided by your employer. This program was created to extend advocacy program benefits to employees like you. Our role is to help facilitate the advocacy process for each eligible member of your employer's health plan and provide access for all high-cost medications.

As it can take a few weeks to get set up, now is the time to begin the process to access your high-cost medications.

Who is Eligible?

Your employer is making this program available to members enrolled in the health plan. If you are currently on a high-cost prescription medication, you will want to follow the steps below for potential cost savings to you! If you are eligible to participate in the SHARx program to lower drug costs for you and your family, follow the instructions in the welcome email or call 314-451-3555.

Instructions to Create Your Advocacy Request

If you have been identified as having a high-cost medication, you will receive a welcome email from SHARx.

After receiving the email, please follow the instructions in the email:

1

Click on the custom link in the email to create an account on the SHARx platform.

2

Validate your identity and set up a user account for the website.

3

After logging in, you can verify the prescription information we have on file for you (and your dependents).

4

Sign the HIPAA form and we'll get to work finding the best option for your medication(s).

If you do not receive a welcome email or are prescribed a high-cost medication in the future, please email sharx@sharxplan.com or call 314-451-3555.

What are the costs?

There are no costs to participate in the SHARx program. Your employer has paid 100% of the cost of this service for you and your family as long as you are enrolled in your employer's health plan. Prescriptions obtained through this service could be FREE for you and your family. Sometimes a co-pay or out of pocket amount will be required, but this out of pocket may be substantially less than what you are paying now.

What happens if I don't enroll in the SHARx program?

Your high-cost medications will no longer be covered by your employer pharmacy benefit plan.



If you are in the advocacy process with SHARx, you may be eligible for a short supply of your urgent medications at your local pharmacy while the advocacy is in process.



Certain manufacturers will require additional information to verify your income.



Please respond right away to these requests for additional information to ensure there is no delay with your advocacy.



Our goal is for everyone to receive the medications they need as quickly as possible at the lowest price, and this is only accomplished with your help.

What is considered a High-Cost Prescription?

Any medication that has a cost of at least \$350 per month is considered high-cost. These would include: Insulin (all types), Abilify, Actemra, Advair, Ajoy, Atripla, Biktarvy, Breo, Brilinta, Budesonide, Bydureon, Cimzia, Concerta, Copaxone, Cosentyx, Creon, Descovy, Dexilant, Dulera, Effient, Eliquis, Elmiron, Enbrel, Entyvio, Farxiga, Flovent HFA, Genvoya, Gilenya, Glatopa, Glyxambi, Humira, Invokana, Janumet, Januvia, Jardiance, Lantus, Latuda, Lialda, Lyrica, Multaq, Otezla, Pentasa, Premarin, Remicade, Repatha, Restasis, Spiriva, Stelara, Symbicort, Takhzyro, Taltz, Toujeo, Truvada, Victoza, Xarelto, Xeljanz, Xolair, and MANY, MANY More!!





What can I expect?

It is important to note that this is not an overnight solution and usually takes from two to four weeks on average to implement your cost savings, depending on outside circumstances of doctor cooperation, ease of communication and understanding. You may also be asked to verify your income, so please respond right away. Be patient with this process and realize that SHARx advocates want to help you.

How will I receive my prescriptions that are not high-cost?

You will continue to use your same pharmacy for acute and low-cost maintenance medications. You are welcome to see if the SHARx program can save you money on low-cost maintenance medications by visiting www.sharxplan.com/generics. Often you can receive a year's supply of maintenance medications for less than you would pay over the course of a year using your insurance copays. Use coupon code SHARx5 for \$5 off your first order.

A glimpse into how SHARx can help you too!

"SHARx has really saved my life and I cannot thank them enough for all of their help! I have multiple medical problems and without them it would simply boil down to deciding what to go without!"

- 5 star Google Review
from Walter H.

Watch this video
to learn more
about SHARx!





SHARx Contacts for Members



Members

- SHARx Member Portal: app.sharxplan.com
- Phone: 314.451.3555, option 1
- Email: SHARx@sharxplan.com
- Fax: 314.451.3555
- Fax for Prescriptions: 314.628.0394
- Self-ID Link (if applicable):



Hours of Operation

- Monday-Friday
- 8:00AM – 5:00PM CT

For General SHARx Questions

- If you have questions regarding the status of your medication or if you need assistance with your SHARx Portal, please contact your Advocacy Team via phone call, text message, by email at sharx@sharxplan.com, or by sending a message in your SHARx Portal.

For questions regarding a Prior Authorization

- Contact your insurance provider via the phone number listed on your ID card

Please click on the video below
to learn about the SHARx
Program

<https://sharxplan.com/oevideo>



You've got HealthiestYou all summer long



Talk to a doctor anytime, anywhere by phone or video.

We can treat allergies, insect stings, rashes and much more at home or on the go. Set up your account today.



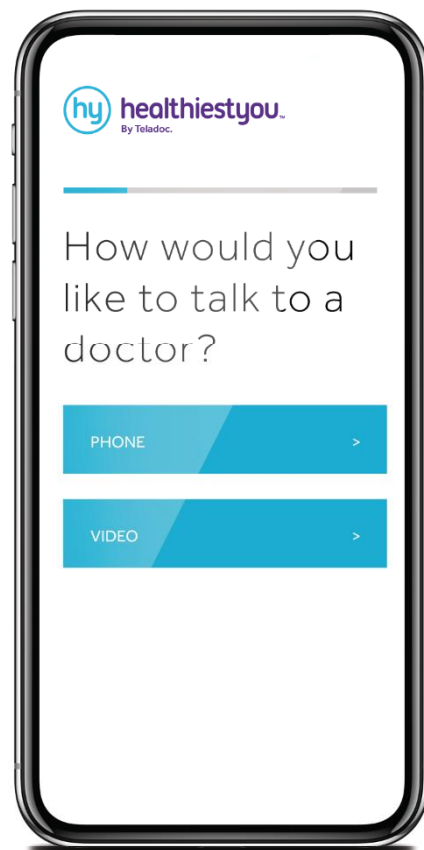
Speak with a doctor within an hour
Talk to a U.S.-licensed doctor from wherever you are



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Our doctors treat conditions like the flu, bronchitis and much more



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Talk to a doctor without waiting hours or weeks for care



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Need care for non-urgent and common conditions? Get a same-day appointment with a certified clinician from wherever you are.

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Start an online skin review with a dermatologist by uploading images and details of your concern. Get a treatment plan and prescription if needed in 24 hours or less.



Discover digital content and resources based on your goals and needs. Recommended activities and content. Explore skill building tools and resources based on your ongoing needs and preferences.

Need a second opinion? Get assurance and advice on a diagnosis, treatment or surgery from leading experts in over 450 specialties.

Members work directly with registered dietitians who assess clinical nutrition needs and develop personalized programs including custom meal plans and shopping guides

Therapy Overcome pain from home, in partnership with Sword Health, through a custom plan from a physical therapist and personalized content.

Visit HealthiestYou.com | Call 1-866-703-1259 | Download the app |

Vision Plan Summary

Metropolitan Life Insurance Company

With your Vision Preferred Provider Organization Plan, you can:

- Go to any licensed vision specialist and receive coverage. Just remember your benefit dollars go further when you stay in network.
- Choose from a large network of ophthalmologists, optometrists and opticians, from private practices to retailers like Costco® Optical, Walmart, Sam's Club and Visionworks.

In-network value added features:

Additional lens enhancements: In addition to standard lens enhancements, enjoy an average 20-25% savings on all other lens enhancements.¹

Savings on glasses and sunglasses: Get up to 20% savings on additional pairs of prescription glasses and non-prescription sunglasses, including lens enhancements. At times, other promotional offers may also be available.¹

Laser vision correction:² Potential savings averaging 15% off the regular price or 5% off a promotional offer for laser surgery including PRK, LASIK and Custom LASIK. This offer is only available at MetLife participating locations.

In-network benefits

There are no claims for you to file when you go to a participating vision provider. Simply pay your copay and, if applicable, any amount over your allowance at the time of service.

	Frequency
Eye exam	Once every 12 months
• Eye health exam, dilation, prescription and refraction for glasses: At no additional cost after a \$10 copay. • Retinal imaging: At no additional cost Up to a \$39 copay on routine retinal screening when performed by a private practice provider.	

Frame	Once every 24 months
• Allowance: \$150 after \$25 eyewear copay. • Costco, Walmart and Sam's Club: \$85 allowance after \$25 eyewear copay. You will receive an additional 20% savings on the amount that you pay over your allowance. This offer is available from all participating locations except Costco, Walmart and Sam's Club.	

Standard corrective lenses	Once every 12 months
• Single vision, lined bifocal, lined trifocal, lenticular: At no additional cost after \$25 eyewear copay.	

Standard lens enhancements¹	Once every 12 months
• Polycarbonate (child up to age 18) and Ultraviolet (UV) coating: At no additional cost after \$25 eyewear copay. • Progressive Standard, Progressive Premium/Custom, Polycarbonate (adult), Photochromic, Anti-reflective, Scratch-resistant coatings and Tints: Your cost will be limited to a copay that MetLife has negotiated for you. These copays can be viewed after enrollment at www.metlife.com/mybenefits.	

Contact lenses instead of eye glasses	Once every 12 months
• Contact fitting and evaluation: At no additional cost with a maximum copay of \$60. • Elective lenses: \$150 allowance. • Necessary lenses: At no additional cost after eyewear copay.	

We're here to help

Find a Vision provider at www.metlife.com/vision

Download a claim form at www.metlife.com/mybenefits

For general questions go to www.metlife.com/mybenefits or call 1-855-MET-EYE1 (1-855-638-3931)

Summary of Benefits - Dental

The following benefits are per Participant per Plan Year. All benefits are subject to the Maximum Allowable Charge.

DENTAL CARE DEDUCTIBLE*, PER PLAN YEAR	
Per Covered Person	\$50
<i>*Plan Year Deductible does NOT apply to Preventive Services or Orthodontia. It only applies to Basic and Major Services.</i>	

MAXIMUM BENEFIT AMOUNT	
Plan Year Maximum Benefit per Covered Person <u>Excluding</u> Prosthetic, Periodontic, Surgical Extractions & Related Anesthesia	\$1,200
Five (5) Year Maximum Benefit per Covered Person Prosthetic, Periodontic, Surgical Extraction & Related Anesthesia	\$2,000
Lifetime Maximum Benefit per Covered Person Orthodontia Only (limited to Dependent Children)	\$1,500

Covered Dental Expenses	Benefit	Limits**
<u>Class A</u> Preventive & Diagnostic Services	Covered in Full (Dental Care Deductible does not apply)	See Dental Benefits Section
<u>Class B</u> Basic Services	80% after Dental Care Deductible	See Dental Benefits Section
<u>Class C</u> Major Services	50% after Dental Care Deductible	See Dental Benefits Section
<u>Class D</u> Orthodontia Limited to Dependent Children Length of Treatment Maximums 0-36 Months: \$1,500 0-18 Months: \$1,364 0-12 Months: \$780	Covered in Full (Dental Care Deductible does not apply)	See Dental Benefits Section
**Dental benefits also subject to the General Limitations and Exclusions section.		

Powered by People



Driven by Results



A Global Medical Response Solution

Welcome to AirMedCare Network. As an employee of Rend Lake College, you and everyone residing in your household are covered by the largest Air Ambulance in the United States.

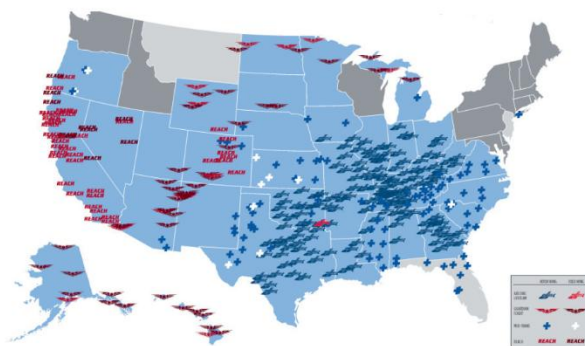
Your membership guarantees no out-of-pocket expense if flown by one of the AirMedCare Network Providers. This is regardless of what insurance does or doesn't cover.



For questions about your membership or to add household members to your plan, feel free to contact Sam Wilson. 618.314.6294 or email at samuel.wilson2@gmr.net



Your membership provides scene care at your home or business, on the road, out and about, and hospital-to-hospital transfers.



Coverage in over 38 states and over 320+ locations.

What to do if you have an emergency.

1. Call 911
2. It's determined you have to be flown.
3. Inform them that you have an AirMedCare Network (Air Evac) Membership.
4. You or your household member is transferred to the nearest appropriate hospital.
5. When provided by one of our providers and having membership, you can recover without financial worry, knowing that all out-of-pocket flight expenses are covered.



Benefit Plan Cost

Rend Lake College offers an all-inclusive benefits package that includes Medical, Dental, and vision. The rates below reflect the combined cost of those benefits.

Rend Lake College pays 100% of the Employee Only Premium and \$1,010 for Dependent Costs

	Employee Monthly	Employee Cost Per Pay (24)
Employee Only	\$0.00	\$0.00
Employee Spouse	\$1,222.00	\$611.00
Employee & Family	\$2,340.00	\$1,170.00

Carrier Contacts

Our goal is to make certain that you receive the correct coverage under the benefits plan. We are here to help with any issues that may arise. Follow these steps if you require assistance:

- **Do you need an ID card?** If you do not have an ID card, please contact the insurance carrier to order your ID card or go online to the carrier's site to download an ID card.
- **For claims assistance**, please contact the insurance carrier. You will need your ID number or Social Security number along with date of service and provider name.

BENEFITS	CARRIER	TELEPHONE	WEB ADDRESS
Medical	PBA	1-888-839-5369	www.pbaclaims.com
Pharmacy Benefit	True Rx	1-866-921-4047	www.truerx.com
Dental	PBA	1-888-839-5369	www.pbaclaims.com
Vision	Met Life	1-855-638-3931	www.metlife.com/vision
Teladoc	Healthiest You	1-866-703-1259	www.healthiestyou.com
High-Cost Medication Program	SHARx	314-451-3555 Opt. 1	www.sharxplan.com
Broker Contacts AssuredPartners	Scott Shouse Lacy Haley	812-482-2855 812-485-2848	Scott.Shouse@assuredpartners.com Lacy.Haley@assuredpartners.com



2026 Compliance Notices

Health Insurance Portability and Accountability Act (HIPAA)

For purposes of the health benefits offered under the Plan, the Plan uses and discloses health information about you and any covered dependents only as needed to administer the Plan. To protect the privacy of health information, access to your health information is limited to such purposes. The health plan options offered under the Plan will comply with the applicable health information privacy requirements of federal Regulations issued by the Department of Health and Human Services. The Plan's privacy policies are described in more detail in the Plan's Notice of Health Information Privacy Practices or Privacy Notice. Plan participants in the Company-sponsored health and welfare benefit plan are reminded that the Company's Notice of Privacy Practices may be obtained by submitting a written request to the Human Resources Department. For any insured health coverage, the insurance issuer is responsible for providing its own Privacy Notice, so you should contact the insurer if you need a copy of the insurer's Privacy Notice.

Newborns' and Mothers' Health Protection Act

Group health plans and health 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 issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours if applicable).

Notice Regarding Special Enrollment

If you are waiving enrollment in the Medical plan for yourself or your dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your dependents in the Medical plan, provided that you request enrollment within 30 days after your other coverage ends. 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 provided that you request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

States with Individual Mandate

Taxpayers in CA, DC, MA, NJ, RI, and VT (this list is neither complete nor exhaustive) are reminded that your state imposes an individual mandate penalty (tax) should you, your spouse, and children choose to not have (and keep) medical/rx coverage for each tax year. Please consult your tax advisor for how a nonelection for health coverage may affect your tax situation.

Special Enrollment Rights CHIPRA – Children's Health Insurance Plan

You and your dependents who are eligible for coverage, but who have not enrolled, have the right to elect coverage during the plan year under two circumstances:

- You or your dependent's state Medicaid or CHIP (Children's Health Insurance Program) coverage terminated because you ceased to be eligible.
- You become eligible for a CHIP premium assistance subsidy under state Medicaid or CHIP (Children's Health Insurance Program). You must request special enrollment within 60 days of the loss of coverage and/or within 60 days of when eligibility is determined for the premium subsidy.

Genetic Nondiscrimination

The Genetic Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting, or requiring, genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, the Company asks Employees not to provide any genetic information when providing or responding to a request for medical information. Genetic information, as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

Qualified Medical Child Support Order

QMCSO is a medical child support order issued under State law that creates or recognizes the existence of an "alternate recipient's" right to receive benefits for which a participant or beneficiary is eligible under a group health plan. An "alternate recipient" is any child of a participant (including a child adopted by or placed for adoption with a participant in a group health plan) who is recognized under a medical child support order as having a right to enrollment under a group health plan with respect to such participant. Upon receipt, the administrator of a group health plan is required to determine, within a reasonable period of time, whether a medical child support order is qualified, and to administer benefits in accordance with the applicable terms of each order that is qualified. In the event you are served with a notice to provide medical coverage for a dependent child as the result of a legal determination, you may obtain information from your employer on the rules for seeking to enact such coverage. These rules are provided at no cost to you and may be requested from your employer at any time.

2026 Compliance Notices (continued)

Notice of Required Coverage Following Mastectomies

In compliance with the Women's Health and Cancer Rights Act of 1998, the plan provides the following benefits to all participants who elect breast reconstruction in connection with a mastectomy, to the extent that the benefits otherwise meet the requirements for coverage under the plan:

- reconstruction of the breast on which the mastectomy has been performed;
- surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- coverage for prostheses and physical complications of all stages of the mastectomy, including lymphedemas.

The benefits shall be provided in a manner determined in consultation with the attending physician and the patient. Plan terms such as deductibles or coinsurance apply to these benefits.

Women's Preventive Health Benefits

The following women's health services are considered preventive. These services generally will be covered at no cost share, when provided in network:

- Well-woman visits (annually and now including prenatal visits)
- Screening for gestational diabetes
- Human papilloma virus (HPV) DNA testing
- Counseling for sexually transmitted infections
- Counseling and screening for human immunodeficiency virus (HIV)
- Screening and counseling for interpersonal and domestic violence
- Breast-feeding support, supplies and counseling
- Generic formulary contraceptives are covered without member cost-share (for example, no copayment). Certain religious organizations or religious employers may be exempt from offering contraceptive services.

Uniformed Services Employment and Reemployment Rights Act (USERRA)

If you leave your job to perform military service, you have the right to elect to continue your existing employer-based health plan coverage for you and your dependents (including spouse) for up to 24 months while in the military. Even if you do not elect to continue coverage during your military service, you have the right to be reinstated in your employer's health plan when you are reemployed, generally without any waiting periods or exclusions for pre-existing conditions except for service-connected injuries or illnesses.

Mental Health Parity and Addiction Equity Act of 2008

This act expands the mental health parity requirements in the Employee Retirement Income Security Act, the Internal Revenue Code and the Public Health Services Act by imposing new mandates on group health plans that provide both medical and surgical benefits and mental health or substance abuse disorder benefits. Among the new requirements, such plans (or the health insurance coverage offered in connection with such plans) must ensure that: the financial requirements applicable to mental health or substance abuse disorder benefits are no more restrictive than the predominant financial requirements applied to substantially all medical and surgical benefits covered by the plan (or coverage), and there are no separate cost sharing requirements that are applicable only with respect to mental health or substance abuse disorder benefits.

Notice to Covered Members

The plans you have selected through your employer-provided employee benefits program are insured by the carrier listed on the confirmation statement or are self-funded plans and the listed carriers is the Plan's claims payer. Administrative services for the billing and collection of premiums from your plan sponsor for the insurance coverages are provided by AP Benefit Advisors, LLC, a licensed Third Party Administrator, pursuant to the agreement previously entered into by AP Benefit Advisors, LLC and the insurer/claims payer. The insurer/claims payer is responsible for eligibility and benefit determination, payment of claims, and all other services associated with your coverage.

2026 Compliance Notices (continued)

COBRA

Under the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985, COBRA qualified beneficiaries (QBs) generally are eligible for group coverage during a maximum of 18 months for qualifying events 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. COBRA coverage is not extended for those terminated for gross misconduct. Upon termination, or other COBRA qualifying event, the former employee and any other QBs will receive COBRA enrollment information. Qualifying events for employees include voluntary/involuntary termination of employment and the reduction in the number of hours of employment. Qualifying events for spouses or dependent children include those events above, plus, the covered employee becoming entitled to Medicare; divorce or legal separation of the covered employee; death of the covered employee; and the loss of dependent status under the plan rules. If a QB chooses to continue group benefits under COBRA, they must complete an enrollment form and return it to the Plan Administrator with the appropriate premium due. Upon receipt of premium payment and enrollment form, the coverage will be reinstated. Thereafter, premiums are due on the 1st of the month. If premium payments are not received in a timely manner, Federal law stipulates that your coverage will be canceled after a 30-day grace period. If you have any questions about COBRA or the Plan, please contact the Plan Administrator. Please note, if the terms of the Plan and any response you receive from the Plan Administrator's representatives conflict, the Plan document will control.

Health Insurance Marketplace

The Patient Protection Affordability Care Act ("PPACA") was signed into law on March 23, 2010. Under PPACA, individuals are required to have creditable health insurance coverage or pay a penalty (if applicable) to the Internal Revenue Service. This is known as the Individual Mandate. For more information on the details of PPACA please visit <https://www.dol.gov/agencies/ebsa/laws-and-regulations/laws/affordable-care-act/for-workers-and-families>. PPACA created a new way to buy health insurance which is called the Health Insurance Marketplace ("Marketplace"), also known as Exchanges. These Marketplaces are established by each individual state, the federal government or as a partnership between the state and the federal government. Through the Marketplaces, individuals can compare and purchase coverage (with a possible premium subsidy for those qualifying as low income; subsidies are made available as a federal tax credit through the Marketplace for individuals that are not eligible for coverage through their employer. If you are enrolled in The Company's medical plan, then PPACA may have little effect on you. The Company's medical plans meet or exceed the minimum coverage requirements set by PPACA. If you are eligible for our plans, you will not be eligible for federal tax credits. You still have the option to visit the Marketplace to see the coverage options available. If you purchase a health plan through the Marketplace instead of purchasing health coverage offered by The Company, you will lose any contribution your employer makes for your health coverage, and your payments for coverage through the Marketplace will be made on an after-tax basis. (See <https://www.healthcare.gov/have-job-based-coverage/>). If you are not eligible to enroll in The Company's medical plan, you may have a few options to purchase medical coverage. These options, if applicable, may include but are not limited to: your spouse's medical plan, your parent's medical insurance plan (if you are under age 26), or from several insurance companies offered through the Marketplace. If you shop for coverage through the Marketplace, you may be eligible for a federal tax credit and/or subsidy if you qualify as low income. (See also: [healthcare.gov](https://www.healthcare.gov)).

How Can I Get More Information?

For more information about purchasing medical coverage through the Marketplace please visit [healthcare.gov](https://www.healthcare.gov) or call 1-800-318-2596.