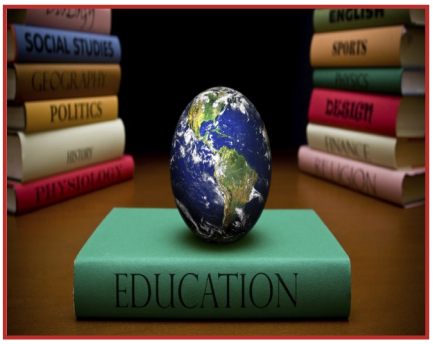
2018
EMPLOYEE BENEFITS ENROLLMENT GUIDE
Open Enrollment - October 10-31st



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During Open Enrollment all benefits-eligible employees must take one of the following actions:

- Enroll in Benefits, or
- Reconfirm current benefits or make changes, or
- Waive benefits

You may choose one of the four options to complete your Open Enrollment process:

1. Speak with a Benefits Specialist via the Enrollment Call Center.
   - Visit https://bentecworkplace.com/columbus
   - Click on the Call Center option.
   - Follow the prompts to select your appointment date/time between the hours of 10am to 6:30pm ET.
   - You will receive a confirmation email with a phone number to the Call Center.
   - The sessions are conducted over the phone. **The employee must be able to access ESS on a computer at the time of the appointment and be able to print a copy of their ESS confirmation statement for their records.** During the co-browsing sessions, both employee and the Benefit Specialist are able to see the same screen at the same time. **The employee is responsible for entering his/her information into ESS with the assistance of the Benefits Specialist.**
2. **New Scheduling Process This Year** - Speak with a Benefits Specialist in a person at your location. To schedule a time, please visit: https://bentecworkplace.com/columbus. When you click on the link, you can select your desired location. Please follow the prompts to select your appointment date/time. (Limited Availability)
3. Schedule a time to meet at the Computer Lab located at Kingswood or Central Registration. Please visit: https://bentecworkplace.com/columbus and click on your desired Computer Lab location. The Benefits Specialist will be at the above Computer Lab locations to assist with the enrollment process. See page 4 for information.
4. Complete your own enrollment using Employee Self-Service on any internet capable computer.

(Voluntary Benefits enrollments/changes/terminations are not available via Self-Service)

New Employees:

- New employees must enroll during the first 30 days of employment.
- If hired between January 1 and October 1, 2017, **you will need to remember to enroll again during open enrollment**. You will need to enroll for 2017 benefits during your first 30 days of employment, and then you must re-confirm your benefit elections and dependents for 2018 benefits coverage during the open enrollment period using Employee Self-Service (ESS).
- To enroll for Voluntary Benefits after October 1, 2017, new employees must call Customer Service within 30 days of employment to schedule a phone appointment to speak to a Benefits Specialist.

Call 1-800-735-0080

Monday through Friday, 8am to 4:30pm

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About This Booklet

This booklet has been designed to help you understand the Columbus City Schools Employee Benefits Program for the plan year January 1, 2018 through December 31, 2018. It outlines all of the available benefit plans, so you may choose the best possible combination of options for you and your family. Please read this booklet carefully, and if you have any questions not answered here, contact the Benefits Department at 614-365-6475. Benefits information can also be found on the CCS Benefits webpage. Go to ccsoh.us, click on the Staff link and then click on the 2018 Employee Benefits link.

Important Contacts

Benefit Plan	Carrier/ Administrator	Telephone Number	Website
Medical	Medical Mutual of Ohio	1-800-382-5729	www.medmutual.com
Prescription Drugs	Express Scripts	1-866-533-7005	www.express-scripts.com
Dental	Delta Dental	1-800-282-0749	www.DeltaDentalOH.com
Vision	Vision Service Plan (VSP)	1-800-877-7195	www.VSP.com
Basic Term and Supplemental Life Insurance	MetLife	1-800-638-6420	www.metlife.com
Flexible Spending Account	Discovery Benefits	1-866-451-3399	www.discoverybenefits.com
Employee Assistance Plan (EAP)	Guidance Resources	1-800-774-6420	www.guidanceresources.com
Universal Life Insurance	Trustmark	1-800-918-8877	www.trustmarksolutions.com
Term to 100 Life	Allstate	1-800-521-3535	www.allstatebenefits.com/mybenefits
Short Term Disability (STD)	Trustmark	1-800-918-8877	www.trustmarksolutions.com
Critical Illness Insurance	Voya	1-877-236-7564	https://claimscenter.voya.com/static/claimscenter/
Accident Insurance	Voya	1-877-236-7564	https://claimscenter.voya.com/static/claimscenter/
Legal Insurance	LegalEASE	1-888-416-4313	http://vsc-legalease.com
Pet Insurance	VPI Pet Insurance	1-877-PETSVPI	www.eb.petinsurance.com
Voluntary Benefit Enrollment	BenTec	1-800-735-0080	https://bentecworkplace.com/columbus
CCS Benefit Department		1-614-365-6475	ccsoh.us/staff/2018 Employee Benefits

What's new in benefits for 2018?

Here is important information for your review as you prepare to complete your enrollment for 2018.

All employees are <u>required</u> to confirm their benefit elections for 2018. This includes employees who want to continue their current elections or those who choose to waive their benefit coverage.

Employee Self Service (ESS) will be used for the 2018 enrollment process. Benefit choices made during Open Enrollment are effective January 1, 2018. Please make sure that you are able to log on to ESS PRIOR to the start of Open Enrollment. We will provide the following resources to employees to assist with enrollment:

- **Benefits Specialists will visit various locations.** Please visit: https://bentecworkplace.com/columbus to schedule your appointment. Please be advised that Specialists will not be available to meet with every employee at every location. *There will be no sign up sheet for appointments as in the past.*
- **Employees will have the opportunity to talk with a Benefits Specialist over the phone in a Co-Browsing session.** See cover page for detailed instructions.
- **Employees adding dependents to the plan for 2018, or who would like another alternative to enroll with a Benefits Specialist, can set up an appointment at Kingswood or Central Registration** during the available lab times by visiting: https://bentecworkplace.com/columbus. (Available lab dates and times listed on page 5). **<u>Registration for a Lab Time is required.</u>** Please enter Kingswood Data Center, 1091 King Ave, through the Visitor's Entrance on the Virginia Avenue side of the building, OR Central Registration, 430 Cleveland Ave (enter off Jack Gibbs Blvd).
- **Employees can log on ESS and confirm, change or waive their benefits elections without meeting with a Benefits Specialist. Voluntary benefit enrollment/ changes/terminations are not available via ESS.**

Regardless of the method chosen to enroll, the employee is ultimately responsible for ensuring that the enrollment is correct and submitted by October 31, 2017.

Verify Dependents' Social Security Numbers

The Affordable Care Act requires all individuals to have health care coverage and also requires employers to report employees' and their dependents' health care coverage.

All eligible employees received a 1095 C in March 2017 identifying if they, or any of their dependents, had healthcare coverage in 2016. In turn, this same information was reported to the IRS. While we were able to submit our information, many Social Security numbers were identified as incorrect.

Please review and verify that your social security numbers including your dependents are correct in ESS as this could create a problem for you if you are asked to verify your health care coverage by the IRS.

CCS E-Mail—Make sure you can access it and check it regularly!

Your CCS email will be the primary source for the Benefits Team to communicate with you during Open Enrollment. Benefits enrollment status updates, problems with or corrections to your enrollment will be sent to you via your CCS email.

Several Voluntary Benefits will continue to be available including:

- Optional Life Insurance with Long Term Care Benefits - page 23
- Optional Term Life Insurance - page 26
- Short Term Disability - page 24
- Accident Insurance - page 24
- Critical Illness Insurance - page 25
- Legal Insurance (non-CEA members only) - page 26
- Pet Insurance - page 26

During Open Enrollment, you may attend an Information Session with representatives from our current insurance carriers held at several locations. See your CCS Benefits page or email for dates, times, and locations.

Benefit Costs

Core Benefits employee contribution rates information can be found in the Benefits Guide beginning on page 15 or on the CCS Benefits webpage The employee and employer share in the cost of these pre-tax benefits. Voluntary Benefit cost information will be provided by a Benefits Specialist during Open Enrollment. The total cost for these after tax benefits are paid for by the employee with the advantage of group rates and the convenience of payroll deduction. New employees hired after the Open Enrollment period ends may call 1-800-735-0080 to schedule an appointment to learn about Voluntary Benefits and to enroll.

Who's Eligible?

Columbus City Schools provides a benefits package for eligible employees, as shown on the chart below.

Eligible Employees	Ineligible Employees
Full-time teachers	Temporary employees
Full-time hourly teachers	All part-time hourly teachers (i.e. LLI, Read 180, Home Instruction)
Half-time teachers working at least 50%	Summer school employees
Full-time administrators	Substitutes
Latchkey teachers	Employees working less than 20 hours per week
Severe Learning Disability Tutors working a minimum of 15 hours per week	
Classified supervisors	
Classified employees working a minimum of 20 hours per week	

Dependents Eligibility Definitions and Required Documents

Dependent Type	Definition	Required Document(s) for Verification
Spouse	A current legal spouse of an eligible CCS employee	1. Original certified or uncertified copy of marriage certification issued by county register — with appropriate signatures (certificates issued by religious institutions will not be accepted) **AND** 2. a. Page 1 and signature page of employee's most recent Federal Income Tax Return (1040, 1040A or 1040EZ) listing the spouse; **OR** b. Page 1 and certificate of Electronic Filing of employee's most recent Federal Income Tax Return (1040, 1040A or 1040EZ) listing the spouse.
Biological, Adopted, Stepchild, or Foster child under age 23 for dental and under age 26 for medical and vision	Child can be married or unmarried (child's spouse and any of the child's dependents are not eligible for coverage.) Child does not have to live with parents, be an IRS dependent or a student. - For dental - dependent will be removed the day he/she turns 23 - For medical and vision - dependent removed from coverage at end of month dependent turns 26	Birth Certificate Child Support Court Order Adoption Court Award Guardianship Court Award (until age 18)
Disabled Overage Dependents	Opportunity to continue **medical coverage only** beyond normal age limit	Proof of handicapped status verified by dependent's physician. (for medical benefits only)

Adding A Dependent To Your Benefits During Open Enrollment

If you are adding new dependents to your Core Benefits, you must provide their eligibility verification documentation before your enrollment will be processed.

***The Benefits Specialist will not be accepting verification documentation to ensure your privacy, due to the sensitive nature of these documents. All dependent verification documentation must be submitted by October 31, 2017 to ensure coverage for your dependents beginning January 1, 2018.**

You will have 2 options to provide your dependent verification documents to the Benefits Department prior to the October 31, 2017 deadline. You can:

- Bring the documentation verifying dependent eligibility with you to complete your dependent enrollment at the Kingswood Data Center (1091 King Ave 43212) or Central Enrollment (430 Cleveland Ave. 43215) during the available lab times below.

Open Computer Lab—Dates and Times

- Thursday, Oct 12 - 3-6 pm - Kingswood Data Center
- Friday Oct 13 - 3-6 pm - Central Enrollment
- Tuesday Oct 17 - 3-6 pm - Central Enrollment
- Thursday Oct 19 - 3-6 pm - Central Enrollment
- Tuesday Oct 24 - 3-6 pm - Kingswood Data Center
- Wed Oct 25 - 8-5 pm Central Enrollment (Records Day)
- Monday Oct 30 - 3-6 pm Central Enrollment

- The second option is to **email** your Core Benefits Confirmation Statement from ESS, along with your verification documentation to the Benefits Department at **benefitquestions@columbus.k12.oh.us**. Please ensure that your six digit Employee Identification number is legible on all documents.

- If you are unable to go to an open lab time or email your documents, please feel free to visit the benefits team at the CEC between 8 a.m. and 5 p.m. Please ensure that your six digit Employee Identification number is legible on all documents. ***Do not fax any documents to the benefits team; they will not be accepted.***

Verify that dependents are on your benefits plans by ensuring their names are included on your confirmation statement.

Steps to Add a New Dependent in ESS

You will need to add each dependent to each benefit in which the dependent is to be enrolled. For example, if you wish to enroll your dependent in medical, dental and vision benefits, you will need to repeat the process of adding that dependent for coverage for each of these benefits.

- You will need to enter the dependent's birth date in this format: (MM/DD/YYYY)
- You will need to enter your dependent's social security number in this format: ###-##-#####.
  Make sure this is correct!
- If you do not enter the dependent information, the enrollment will be rejected by the insurance company when the data is transmitted at the end of Open Enrollment.
- If you are adding a dependent, you are required to provide documentation verifying their eligibility. **If this documentation is not provided during open enrollment, we will remove the dependent and notify you via CCS e-mail.**

How to Enroll, Change or Waive Coverage

Existing Employees

During the annual Open Enrollment, you **MUST** enroll or waive coverage; coverage begins January 1, 2018. For 2018, you may enroll through ESS or by speaking with a Benefits Specialist. (See **page 4** for additional information)

If you elect to waive benefits coverage through Columbus City Schools (CCS) , you will need to decline benefit coverage in ESS.

New Hires After October 1, 2017

If you are a new employee, during your first 30 days of employment, you will have an opportunity to enroll in your Core Benefits by completing the enrollment form and submitting it to the Benefits Department. You may also enroll in Voluntary Benefits during your first 30 days of employment by visiting https://bentecworkplace.com/columbus to schedule a Voluntary Benefit enrollment session. No action is required for Open Enrollment. Your benefits will roll over automatically.

New Hires between January 1 and October 1, 2017,

You must enroll twice – If you have enrolled for the remainder of 2017 by submitting your paper form to the benefits office, you will need to reconfirm your elections for 2018 benefit coverage, using Employee Self-Service (ESS).

When Coverage Begins

If you are a current employee and enroll during the annual Open Enrollment period, your new coverage selections will be effective January 1, 2018. If you are a new hire, have transferred into a benefits-eligible position, or returned from an unpaid leave of absence during which time you let your benefits coverage lapse, you will need to enroll for benefits coverage within 30 days of hire, your transfer date or your return to work date. Benefits will be effective on the first day of the month 30 days after your hire date as a new hire. For other changes, like qualifying events, benefits are effective on the date of a qualifying event. For more information about qualifying events, see the information available on this page.

When Coverage Ends

Core Benefits will terminate on the last day of the month indicated on the Payroll and Deduction Schedule corresponding to the last earnings period in which the employee works. Contact the Benefits Department for specific dates. **For dependents up to age 26,** medical/vision coverage ends at the end of the month in which the dependent reaches age 26. Dental coverage ends on the date the dependent turns 23. Most Voluntary Benefits are portable and you can continue them when you leave your employment by paying premiums directly to the insurance company. You will need to contact the provider directly. **Benefits Specialists cannot terminate your Voluntary Benefits.**

Terminating Voluntary Benefits

If you wish to terminate a Voluntary Benefit you must:

- Contact the Voluntary Benefit Provider (Contact numbers are available on the inside cover of this guide).
- Complete the Supplemental Insurance Termination Form (available on the CCS Benefits web page) and return the completed form to the Benefits Department.

Making Mid-Year Benefit Changes

Qualifying events (Life or Job Status Changes) provide a 30-day eligibility period for current employees to add or drop dependents and make other eligible changes to benefit coverage. Should a qualifying event occur (Life or Job Status Change), you must inform the Benefits Department within 30 days and provide the required documentation below.

Qualifying Event	Required Documentation
Marriage	Marriage certificate
Divorce	Divorce decree
Legal separation	Court documentation
The birth of a child or children	Birth certificate(s)
Adoption or placement for adoption of a child	Adoption award letter
Your child becomes ineligible for coverage	Complete the proper form to terminate dependent coverage (available from the Benefits Department)
A court issues a Qualified Medical Child Support Order (QMCSO) requiring the plan to provide medical coverage for your dependent child	Copy of support order
Loss of coverage (due to a change in your spouse's employment or your spouse's eligibility for benefits)	Loss of coverage letter from prior insurance provider or prior employer (on their letterhead)
Dependent child gains coverage from an employer	Letter of creditable coverage from an employer

Unpaid Leaves of Absence

If you choose to maintain benefits coverage while on an unpaid Leave of Absence, you are required to pay 100% of the total cost (both employee and employer shares) unless you are covered by FMLA. Your total cost of continuing your benefits coverage is paid directly to the Benefits Department. The Benefits Department will mail a written notice to you specifically outlining required payments to continue coverage for the employee and/or dependent(s). **You are responsible for ensuring that your benefit coverage continues when on leave of absence. If you choose to waive coverage while on unpaid leave, you have 30 days from the date you return to work to reinstate your benefits by completing an enrollment form.**

FMLA (Family and Medical Leave Act of 1993)

The Human Resources Department will determine whether an employee is eligible for FMLA. Under the provisions of FMLA, Columbus City Schools is required to maintain an employee's health benefits for a period not to exceed 12 weeks from the date of leave. Employees will pay for insurance under the same conditions (during those 12 weeks), as if the employee continued active employment. Upon exhaustion of FMLA, the employee is responsible for the total cost to maintain benefits coverage. Once approved for FMLA leave, an employee will receive detailed documentation of his/her benefits continuation eligibility if the employee is in an unpaid status while on leave.

To continue Voluntary Benefits while on leave, the employee must contact the vendor and arrange to make payments directly to them.

Worker's Compensation Leave of Absence

While on an approved Worker's Compensation-related leave of absence, an employee choosing to continue benefits must self-pay for the benefits. The amount charged for Classified employees will be 10% of the total monthly cost of benefits. Certificated employees are responsible for 100% of the cost of continuing coverage (both Employer and Employee shares).

Voluntary Unpaid Leave

If an employee is approved by the Board of Education for an unpaid leave of absence, it is the responsibility of the employee to pay 100% (both Employer and Employee shares) of the cost should he/she choose to maintain benefit coverage. Coverage can continue for up to two years. **If an employee chooses to waive coverage while on unpaid leave, the employee will have 30 days from return to work date to reinstate benefits by completing an enrollment form.**

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Using ESS to Enroll in Benefits for 2018

How to Access ESS (*Use Google Chrome*)
Option 1: http://columbus.munisselfservice.com
Option 2: Access the **CCS website** at: www.ccsoh.us. *Click* the **Staff** link in the middle of the screen. Under the Staff Links section on the page, *Click* ESS link.
Option 3: Access the **CCS Intranet** cpsnet.columbus.k12.oh.us/. On the left side, under **Quick Links,** *click* on the Employee Self-Service (ESS) link.

- **Log in** - The username is your 6-digit employee number. You can find this number on your ID badge or pay statement. **When logging in for the first time**, the password is the last 4 digits of your social security number. You will then be prompted to change your password. The new password must be at least 8 characters and contain at least 1 upper case character, at least 1 lower case character and at least 1 must be numeric. **If you have difficulty logging in, assistance is available by contacting the CCS Help Desk at 614-365-8425 between the hours of 6:30 a.m. and 5:30 p.m.**
  - *Click* on the **Employee Self-Service** link
  - *Click* on the **Benefits** tab on the left side of the screen (this tab shows you your current elections for 2017)
  - *Click* on the **Open Enrollment** tab
- **Once in the Open Enrollment Section**, you will see three columns: Benefit, Current Election, and New Election. Review your 2017 benefits which are listed in the Current Election column. When you make your elections for 2018, your choices and costs per pay period will show up in the New Election column. You will have 3 options in the New Election column for each benefit (except Flexible Spending). These choices are Decline Benefit, No Changes or Make Changes.
- You must click on one of the three choices, in the New Election column: Decline Benefit, No Changes, or Make Changes for each benefit listed. You will not be able to progress and submit your choices until you have made an election or declined EACH of the benefit options on the main screen.
- Make sure that you review your elections to confirm that your dependents are enrolled for each benefit and that the Social Security numbers and birthdates are correct in the system prior to submitting your elections.
- **Make sure to submit your choices and print a copy of your confirmation statement for your records. This verifies your 2017 benefit choices.**

Need Help?

Call the Help Desk to resolve ESS password or log in issues

614-365-8425

Your Core Benefit Choices

About Core Benefits

Your Core benefits include medical, prescription drug, dental, vision care, life insurance, Flexible Spending Accounts and The Employee Assistance Plan (EAP). You can find more information about additional voluntary programs (for which you pay the total cost) beginning on page 23. If you have questions about Core Benefits, contact the Benefits Department at 614-365-6475.

Medical Benefits - Medical Mutual of Ohio

Columbus City Schools offers three different types of medical plans, administered by Medical Mutual of Ohio, from which to choose:

- Select Basic (offered to Classified employees and Classified Supervisors only)
- Select
- Choice

All plans cover the same general types of services and pay benefits toward the cost of preventive care, as well as doctor visits, hospitalization, diagnostic tests, mental health, substance abuse treatment and prescription drugs.

The medical plan options differ in that the Select Basic and Select Plans do not provide benefits for out-of-network providers. Choice covers both in-network and non-network providers. The plans also differ in both the portion of health care expenses that you pay out of your own pocket when you receive care and in the amount of your per pay contributions for coverage.

How The Medical Plans Work

Select Basic (offered to Classified Employees and Classified Supervisors only)

The plan offers lower employee contribution rates than the other options, but higher co-pays and a higher cost for prescription drugs. The plan includes an annual deductible and co-insurance for some services. Non-network services are not covered under this plan, except for approved emergency care.*

Select

The plan offers affordable employee contribution rates and co-pays for many services. Non-network services are not covered under this plan, except for approved emergency care. Co-insurance and deductible amounts vary depending on employee classification. *

Choice

The plan offers higher contribution rates than the other plans and co-pays for services. This plan option offers network coverage but also provides for non-network coverage. Co-insurance and deductible amounts vary depending on employee classification.*

Plan Definitions

Deductible: The amount you must first pay for medical coverage before the plan pays.

Co-Payment: Often referred to as a co-pay, a fixed amount you must pay for covered medical services or prescription medications, typically either at the time of the office visit or when you pay for your prescriptions.

Co-Insurance: After satisfying the deductible, the percentage of covered expenses that insurance will cover.

Out-of-Pocket Maximums: The maximum amount of money you will be required to pay for covered medical services, in a calendar year. Once your share of the covered medical expenses reaches this maximum, Columbus City Schools will pay 100% of your covered charges for the balance of the year.

Dependent: A spouse of an Employee or any child of an eligible Employee, from birth until age 26, with the exception of 23 for Dental.

Your Prescription Drug Benefits

All medical plans include a prescription drug benefit program administered by Express Scripts.*

My Health Plan - Your Personalized Web Portal

All you need to register is your Medical ID card!

Visit the Medical Mutual website (www.medmutual.com) and click on *Register Here* under *My Health Plan Login* on the right side of the page. Using information from your ID card, complete the form fields and click *Agree* to the Terms and Conditions.

Time, Money and Total Health-Saving Features

In addition to ordering new ID cards, you have access to online customer service and 24/7 access to your benefit book, *My Health Plan*, and:

- **Paperless Explanation of Benefits (EOBs)** – A digital archive of current and past EOBs keeps these important records organized and easily accessible. Along with the option to receive paperless EOBs, you can choose to opt out of receiving mailed copies.
- **Health Assessment** – Complete this online questionnaire about your medical history and lifestyle to receive a complementary personalized report that includes recommendations you can use to improve your health.

*For details, see the medical/prescription summaries included in this guide on pages 10 and 11

Your Core Benefit Choices

- **Provider Search Tool** – The Provider Search Tool helps you find in-network options by allowing you to search for doctors and medical facilities by name, specialty, gender and more. Using in-network providers ensures you receive the highest level of benefits available under your plan.
- **Treatment Cost Estimator** – The Treatment Cost Estimator helps you make cost-effective choices by calculating approximate costs for certain procedures with in-network providers.

Disease & Maternity Management Programs

Medical Mutual offers the SuperWell® Disease and Maternity Management Program to help those with a chronic health condition or anyone who is currently pregnant. Specially trained Health Coaches provide education and support with an emphasis on increasing your knowledge of your disease or pregnancy. Participation is voluntary and there is no out-of-pocket cost to you. The SuperWell® Disease and Maternity Management Program is available to eligible members who are pregnant or diagnosed with one or more of the following conditions: Asthma, Chronic Obstructive Pulmonary Disease, Chronic Pain conditions, Congestive Heart Failure, Coronary Artery Disease, Depression, Diabetes and Pregnancy.

Is My Doctor In The Network?

If You Are Not A Member:

- Go to providersearch.medmutual.com
- Enter Your Provider Type and Zip Code
- Choose the SuperMed PPO Network
- Choose a specialty and/or Provider Name
- Click Search

If You Are A Member

- Log in to My Health Plan at member.medmutual.com/user/login
- Choose Find a Provider
- Enter Your Provider Type and Zip Code
- Choose a specialty and/or Provider Name
- Click Search

Where To Go For Care

	Why Go?	Type Of Care?	Costs and Time Consideration?
Nurse Line **$0**	A free call-in service providing 24/7 access to registered nurses for answers to health related questions. To use the service call 888-912-0636.	• Guidance on the type of care needed for your illness or injury • Can explain medical tests and your results • Will help you to determine if you should go to the emergency room.	• No Cost • No appointment needed • Available 24/7 • Telephonic or online advice (not face to face)
Telemedicine **$ Office visit co-pay**	A 24/7 telephone/online video service providing access to a board-certified physician. Wait times to speak to a doctor are typically less than 10 min.	• Allergies • Bronchitis • Cold and Flu Symptoms • Respiratory Infection • Sinus Problems • Sprain or Strain • Urinary Tract Infection	• Requires a co-pay • No appointment needed • Available 24/7 • Will typically be seen by a doctor within 30 min or less from the time of your request
Doctor's Office **$**	A place for routine care or treatment for a current health issue and preventive treatment.	• Routine Checkups • Immunizations • Preventive Services • Managing General health • Physicals	• Rquires a co-pay • Normally requires an appointment • Small wait times with an appointment
Convenience Clinic **$**	A walk-in clinic located in some drug and grocery stores, staffed by a physician's assistant or nurse practitioner. Convenience clinics don't require an appointment and have shorter than average wait times.	• Common infections like strep throat • Minor skin rashes like poison ivy • Flu Shots • Physicals • Minor Cuts • Ear Aches	• Requires a co-pay and/ or co-insurance similar to a doctor's office visit • No appointment needed • Availability based on the clinic • Without an appointment, wait times may vary
Urgent Care **$$**	A walk-in clinic that saves time and money compared to an emergency room. Many are open evenings and weekends. Urgent Care facilities don't require an appointment and have average wait times.	• Strains and Sprains • Broken Bones (minor) • Infections (minor) • Burns (minor) • X-Rays	• Requires a co-pay and/ or co-insurance and is higher than a doctor's office visit or convenience care clinic • Walk-in patients welcome, but waiting periods may be longer based on the severity of the illness or injury
Emergency Room **$$$**	A facility found in a hospital, providing 24/7 care in case of emergencies and acute care without prior appointment. ER visits for non-emergency symptoms may result in extremely long wait times and significantly higher costs compared to visiting a non-emergency location.	• Allergic Reaction • Heavy Bleeding • Broken Bone (major) • Sudden Change in Vision • Chest Pain • Cut/Burn (Major) • Head Injury (Severe) • Shortness of Breath • Spinal Injury	• Requires a much higher co-pay and/or co-insurance • Open 24/7, but waiting periods may be longer based on the severity of the illness or injury

*For details, see the medical/prescription summaries included in this guide on pages 10 and 11

Columbus City Schools Medical/Pharmacy Benefit Summaries
Classified Employees & Classified Supervisors

Revised 9/1/2018

	Select	Choice		Select Basic
Benefit		**Network**	**Non-Network**	
Choice of Physician	Member selects a physician from the network	Member selects a physician from the network	Member can also receive care from non-network providers at a lower benefit level	**Member selects a physician from the network**
Annual Medical Deductible - Deductible applies except for services with a copay unless otherwise noted				
Medical Deductible Individual/Family	$200/$600	$50/$100	$600/$1,800	$200/$600
Annual Out-of-Pocket Maximum (OOP)	**Network medical copayments will accumulate to the Out of Pocket Maximum along with any applicable medical deductibles and coinsurance. (See Pharmacy Out of Pocket Maximum below)**			
Medical OOP Individual/Family	$500/$1,000	$500/$1,000	$1,500/$3.000	$500/$1,000
Preventive Care Services (Routine preventive care services. Immunizations)	$0 Copay	$0 Copay	Not Covered	$0 Copay
Physician / Specialist Office Visits	$15 Copay	$15 Copay	30% Coinsurance after deductible	$20 Copay
Urgent Care Visits	$25 Copay	$35 Copay	Not Covered	$35 Copay
Hospital Emergency Room	$100 Copay (waived if admitted)	$100 Copay (waived if admitted)	$100 Copay (waived if admitted)	$100 Copay (waived if admitted)
Inpatient Facility Services	10% Coinsurance after deductible No Physical Medicine & Rehabilitation (PM&R) limit	5% Coinsurance after deductible 60 day combined PM&R limit	30% Coinsurance after deductible 60 Day PM&R limit	10% Coinsurance after deductible
Outpatient Facility Services	10% Coinsurance after deductible	5% Coinsurance after deductible	30% Coinsurance after deductible	10% Coinsurance after deductible
Chiropractic Services (30 Visits per year)	$5 Copay	$5 Copay	30% Coinsurance after deductible	$10 Copay
Physical and Occupational Therapy (60 visit level combined per year)	$5 Copay	$5 Copay	30% Coinsurance after deductible	$10 Copay
Speech Therapy (20 visits per year)	$15 Copay	$15 Copay	30% Coinsurance after deductible	$20 Copay
DME – Medical Supplies, Equipment and Appliances	20% Coinsurance after deductible	20% Coinsurance after deductible	20% Coinsurance after deductible	20% Coinsurance after deductible
Diabetic/Asthmatic Supplies	$0 Copay	$0 Copay	Not Covered	$0 Copay
Human Organ/Tissue Transplant	Plan pays 100%	Plan pays 100%	Not Covered	Plan pays 100%
Mental Health/ Substance Abuse Inpatient Services	Plan pays 100% after deductible	Plan pays 100% after deductible	20% Coinsurance after deductible	10% Coinsurance after deductible
Mental Health/ Substance Abuse Outpatient Services	$5 Copay	$5 Copay	20% Coinsurance	$20 Copay
Home Health Care	0% Coinsurance after deductible	0% Coinsurance after deductible	20% Coinsurance after deductible (30 visit limit per year)	0% Coinsurance after deductible
Hospice Services	0% Coinsurance after deductible	0% Coinsurance after deductible	0% Coinsurance after deductible	0% Coinsurance after deductible
Pharmacy OOP Individual/Family	$1,500/$3,000	$1,500/$3,000	$2,500/$5,000	$1,500/$3,000
Prescription Drugs Retail Pharmacy (30 day supply)	$4 Generic / $15 Brand Preferred / $30 Brand Non-Preferred	$4 Generic / $15 Brand Preferred / $30 Brand Non-Preferred	50% Coinsurance	$10 Generic / $20 Brand Preferred / $30 Brand Non-Preferred
Prescription Drugs Mail Order Pharmacy (90 day supply)	$8 Generic / $30 Brand Preferred / $60 Brand Non-Preferred	$8 Generic / $30 Brand Preferred / $60 Brand Non-Preferred	Not Covered	$20 Generic / $40 Brand Preferred / $60 Brand Non-Preferred
Dependent Child Age	Up to age 26			

Teachers & Administrators/Eligible Tutors/Latchkey Teachers/Job Share Teachers

	Select	Choice	
Benefit		**Network**	**Non-Network**
Choice of Physician	Member selects a physician from the network	Member selects a physician from the network	Member can also receive care from non-network providers at a lower benefit level
Annual Medical Deductible - Deductible applies except for services with a copay unless otherwise noted			
Medical Deductible Individual/Family	$250/$500	$250/$500	$500/$1,000
Annual Out-of-Pocket Maximum (OOP)	**Network medical copayments will accumulate to the Out of Pocket Maximum along with any applicable medical deductibles and coinsurance. (See Pharmacy Out of Pocket Maximum below)**		
Medical OOP Individual/Family	$600/$1,200	$600/$1,200	$1,200/$2,400
Preventive Care Services (Routine preventive care services. Immunizations	$0 Copay	$0 Copay	Not Covered
Physician /Specialist Office Visits	$20 Copay	$20 Copay	20% Coinsurance after deductible
Urgent Care Visits	$25 Copay	$35 Copay	Not Covered
Hospital Emergency Room	**$100 Copay (waived if admitted)**	**$100 Copay (waived if admitted)**	**$100 Copay (waived if admitted)**
Inpatient Facility Services	0% Coinsurance after deductible No Physical Medicine & Rehabilitation (PM&R) limit	0% Coinsurance after deductible 60 day combined PM&R limit	20% Coinsurance after deductible 60 day combined PM&R limit
Outpatient Facility Services	**0% Coinsurance after deductible**	**0% Coinsurance after deductible**	**20% Coinsurance after deductible**
Chiropractic Services (30 visits per year)	$20 Copay	$20 Copay	20% Coinsurance after deductible
Physical and Occupational Therapy (60 visits per year combined)	$20 Copay	$20 Copay	20% Coinsurance after deductible
Speech Therapy (20 visits per year)	$20 Copay	$20 Copay	20% Coinsurance after deductible
DME – Medical Supplies, Equipment and Appliances	20% Coinsurance after deductible	20% Coinsurance after deductible	
Diabetic/Asthmatic Supplies	$0 Copay	$0 Copay	Not covered
Human Organ /Tissue Transplant	Plan pays 100%	Plan pays 100%	Not covered
Mental Health/ Substance Abuse Inpatient Services	0% Coinsurance after deductible	0% Coinsurance after deductible	20% Coinsurance after deductible
Mental Health/ Substance Abuse Outpatient Services	$20 Copay	$20 Copay	20% Coinsurance after deductible
Hospice Services	Plan Pays 100%	Plan Pays 100%	
Home Health Care	0% Coinsurance after deductible	0% Coinsurance after deductible	20% Coinsurance after deductible
Pharmacy Out of Pocket Maximum Individual/Family	$1,500/$3,000	$1,500/$3,000	$2,500/$5,000
Prescription Drugs Retail Pharmacy (30 day supply)	$4 Generic / $25 Brand Preferred / $40 Brand Non-Preferred	$4 Generic / $25 Brand Preferred / $40 Brand Non-Preferred	50% Coinsurance
Prescription Drugs Mail Order Pharmacy (90 day supply)	$10 Generic / $50 Brand Preferred / $80 Brand Non-Preferred	$10 Generic / $50 Brand Preferred / $80 Brand Non-Preferred	Not Covered
Dependent Child Age	Up to age 26		

Notes: Above summaries are for reference only. Please consult summary plan document, amendments, and riders for exact plan

Wellness Programs

Take action to improve your health with access to programs like:

- Weight Watchers®
- Fitness club discounts
- **SuperWell® QuitLine** smoking-cessation program.
- **SuperWell® Health Resource Center** – View videos that give you customized advice based on information you provide. The Resource Center also offers interactive tools and quizzes, a searchable health encyclopedia and a symptom checker.
- **SuperWell® Extras** – Receive discounts on a variety of items including baby products, spas, hearing aids, drugstore items and health products.
- **CCS Wellness Initiative Programs** – Healthy Bodies, Active Minds.

Your Medical Mutual Identification Card

Be sure to carry your ID card with you and present it to any healthcare provider you visit. On your card, you will find:

- Coverage details, such as ID number, group number, group name and type of coverage
- SuperMed Network coverage area and how to find care when traveling
- The phone number to reach the Customer Service department
- The amount owed at time of visit to a healthcare provider (also known as the copay), if applicable

Virtual Doctor's Visit - Cleveland Clinic Express Care® Online

You Don't Need an Appointment. Just a Connection

24/7 care you need right now, from home - or anywhere via your smartphone, tablet, or computer.

When you need to find care, connect from your phone, tablet or computer, at home or work. Now it's never been easier for patients to access the expertise of Express Care Online. Connect within minutes. Get a diagnosis or a prescription from a healthcare provider, when appropriate. All in one 10–minute session.

Columbus City Schools covers telehealth sessions like a regular office visit; just pay your normal co-pay.

Express Care is available for Adults for the following conditions:

Asthma	Bronchitis
Cough and Cold Symptoms	Earaches
Minor Back and Shoulder Pain	Seasonal Allergies
Minor Trauma, Burns, or Lacerations	Sinus Infections
Minor Medical Concerns	Skin Rashes
Urinary Tract Infections	Yeast Infections

Express Care is available for Children (6-17 years old) for the following conditions:

Bronchitis	Conjunctivitis
Cough and Cold Symptoms	Sinus Infections
Minor Medical Concerns	Seasonal Allergies
Skin Rashes	

Getting Started

1. **Mobile devices**: Download the Express Care Online app from either the "App Store" or "Google play".

   Laptop or Desktop users: Go to http://my.clevelandclinic.org/online-services/express-care-online. Get started by using the "See a Provider Now" button and enter your information on the Express Care Online website.

   Computer with webcam: Click the "Test Your Computer" button to make sure you're ready for your visit.

2. You'll be placed into the waiting room after you answer a few questions.

   At this time, your Cleveland Clinic provider will be notified that you're ready for your visit.

Preventive Care Services

Prevent and Detect Disease Early

Staying healthy and living a long life starts with preventive healthcare. Preventive healthcare can help you avoid illness and detect problems before you notice any symptoms – helping you stay healthy. Preventive care includes immunizations, lab tests, screenings and other services intended to prevent illness or detect problems before you notice any symptoms. Your medical benefit includes preventive heath services at no cost because your health is important.

Examples of covered preventive services include many types of exams, subject to age/gender guidelines:

Physician Office Services

Annual Physical Examinations	Immunizations
Well Baby and Child Care	Well Woman and Well Man

Health Screenings, Lab, X-Ray or Health Screening Tests:

Screening Mammography	Screening Colonoscopy
Cervical Cancer Screening	Prostate Cancer Screening
Osteoporosis Screening	

Your Prescription Drug Benefits

All medical plans include a prescription drug benefit program administered by Express Scripts. See pages 10-11 for co-pay information.

Dental Benefits - Delta Dental

Regular, professional dental care is an important part of your family's health care. To help you get that care, Columbus City Schools offers you a Dental Plan with a wide choice of providers. The dental benefit plan is administered by Delta Dental.

Your enrollment decision for the Dental Plan is separate from your medical plan enrollment. This means you may elect or decline coverage in the Dental Plan, whether or not you elect coverage under a medical plan.

Your dental benefits cover you and your eligible enrolled dependents for a variety of services. **NOTE: Dependent eligibility for the Dental Plan ends at age 23. The Health Care Reform legislation does not require extended dependent dental coverage over age 23.**

Dental Provider Choice

You may see any dentist you like. However, there are advantages to choosing a dentist who belongs to one of Delta Dental's two dentist networks. Delta Dental PPO network dentists offer significant fee reductions to Delta Dental members. This minimizes your out-of-pocket costs and maximizes your dental benefits.

You may also choose a dentist from the Delta Dental Premier® network. More than four out of five dentists in Ohio participate in Delta Dental Premier. Fee savings with Delta Dental Premier are not as great as with our PPO network, but Delta Dental Premier offers many advantages over visiting nonparticipating dentists.

Here's how this works:

- Delta Dental participating dentists fill out and submit claim forms for you. Claim payments are sent directly to the dentist. Staying in network makes claims and payment hassle free.
- Delta Dental participating dentists agree to reduced fees, minimizing your out-of-pocket costs. If the dentist's normal charge is higher than Delta Dental's maximum approved fee, the dentist cannot pass the balance on to you. You are protected from balance billing.

If you use a nonparticipating dentist:

- You may have to fill out and submit your own claim forms. Claim payments are sent to the patient. Because of this, the dentist may require you to pay the full cost of treatment up front.
- If the Nonparticipating Dentist does not take advantage of the network discount, there are no limits on what the dentist may charge. If the dentist's normal charge is higher than Delta Dental's maximum approved fee, the dentist can pass the balance on to you. You won't be protected from balance billing.

	Delta PPO/Premier Provider	Non-participating Provider*
Deductible	None	
Annual Calendar Year Maximum	$1,500 per person	
Lifetime Maximum for Orthodontic Treatment	$1,000 per person/lifetime (child or adult)	
	Plan Pays	
Preventive and Diagnostic Services (2x per year check-up and cleaning; X-rays every 3 years)	100%	100%**
Minor Restorative Services (including fillings, root canals, periodontics and oral surgery)	80%	80%**
Major Restorative Services (such as crowns)	80%	80%**
Prosthodontic Services (such as bridgework and dentures)	50%	50%**
Orthodontic Services (no age limit)	50%	50%**

*If you elect a non – participating provider, your share of costs may be slightly higher.
** Of Delta Dental's maximum approved fees.

Vision Benefits - Vision Service Plan (VSP)

If you wish, you may also enroll in a vision care benefit for which the employer pays the full cost for you and your enrolled dependents.*

*Note that Latchkey Teachers are required to pay a portion of the cost for vision benefits.

Your Vision Plan covers you and your eligible enrolled dependents. **NOTE: Dependent eligibility for the Vision Plan ends at age 26.**

Your Vision Plan includes a full range of vision care services provided through a network of preferred vision providers, the Vision Service Provider (VSP) network. You may also receive care from any provider you wish, but your benefits are greater when you see a participating VSP provider.

To locate a participating provider, call VSP at 1-800-877-7195, or visit the VSP website at www.vsp.com. Once you choose a provider, call the provider directly to schedule your appointment.

If you choose a non-participating provider, you will have to file a claim for reimbursement.

	Vision Plan Benefits	
	In-Network	**Out-of-Network**
Covered Services		
Routine eye exam (**every 24 months**)	$10 copay (applies to exam and eyewear materials)	$35 after $10 copay (applies to exam and eyewear materials)
Frames (**every 24 months**)	$105 allowance	$35
Lenses (**every 24 months**)		
Single vision	Covered in full after $10 copay (see above)	$25
Lined Bifocal	Covered in full after $10 copay (see above)	$40
Lined Trifocal	Covered in full after $10 copay (see above)	$55
Contact lenses (every 24 months instead of eyeglass lenses and frames)		
Cosmetic	$105 allowance	$105
Medically necessary	Covered in full after $10 copay (see above)*	$210 allowance**

** Medically necessary lenses are those required to correct serious vision conditions such as following cataract surgery. Most contact lenses worn in place of glasses do not fall into this category.

YOUR WELLNESS BENEFITS

CCS Wellness Initiative Programs - Healthy Bodies, Active Minds

Columbus City Schools is committed to supporting the health and wellness of our employees. The Staff Wellness Committee has developed a program that is designed to cover a broad range of health topics and offers something for every employee.

In addition to the preventive health care coverage and wellness services provided under your medical plan, Columbus City Schools offers you access to a wide variety of additional wellness benefits and programs to help keep you healthy. Be sure to participate in Staff Wellness seminars, and our free fitness classes that are offered at various locations every week.

COLUMBUS CITY SCHOOLS

Teachers & Administrators

2018 Employee Contributions for Benefits

Medical

21 Pay Plan	Select	Choice
Employee only	48.01	56.17
Employee plus one (Spouse on CCS coverage before June 1, 2009, or Child)*	95.73	111.98
Employee plus one **(Including Spouse)**	268.01	284.26
Family (Spouse on CCS coverage before June 1, 2009, and/or Children)*	141.25	165.25
Family **(Including Spouse)**	395.42	419.42

* CEA bargaining unit members or Administrators who add their Spouse **after** May 31, 2009 will pay a higher rate contribution to include their spouse for Health Coverage. * CEA bargaining unit members or Administrators as of May 31, 2009, so long as they are continuously employed by the Board, shall be entitled to enroll a spouse for primary coverage at these rates if a qualifying event occurs. * CEA bargaining unit members or Administrators as of May 31, 2009, who have continuously covered their spouse on their health coverage since May 31, 2009, shall be allowed to continue Spousal coverage at these lower rates during their continuous employment with the district.

Medical

26 Pay Plan	Select	Choice
Employee only	38.77	45.36
Employee plus one (Spouse on CCS coverage before June 1, 2009, or Child)*	77.32	90.45
Employee plus one **(Including Spouse)**	216.47	229.60
Family (Spouse on CCS coverage before June 1, 2009, and/or Children)*	114.09	133.47
Family **(Including Spouse)**	319.38	338.76

* CEA bargaining unit members or Administrators who add their Spouse **after** May 31, 2009 will pay a higher rate contribution to include their spouse for Health Coverage. * CEA bargaining unit members or Administrators as of May 31, 2009, so long as they are continuously employed by the Board, shall be entitled to enroll a spouse for primary coverage at these rates if a qualifying event occurs. * CEA bargaining unit members or Administrators as of May 31, 2009, who have continuously covered their spouse on their health coverage since May 31, 2009, shall be allowed to continue Spousal coverage at these lower rates during their continuous employment with the district.

Dental

	21 Pay Plan	26 Pay Plan
Employee only	4.05	3.27
Family	4.05	3.27

Supplemental Life Insurance ($50,000)

21 Pay Plan	2.94
26 Pay Plan	2.38

Vision Care is fully paid for by Columbus City Schools

COLUMBUS CITY SCHOOLS

Classified Employees / Supervisors

2018 Employee Contributions for Benefits

Medical

21 Pay Plan	Select Basic	Select	Choice
Employee only	11.73	22.94	52.66
Employee + one *	23.38	45.76	105.02
Family *	34.51	67.51	154.94
Employee + one **(Including Spouse)**	233.41	255.79	315.05
Family **(Including Spouse)**	344.39	377.39	464.82
Family (4 hour employee)	954.98	987.99	1,075.42

* OAPSE bargaining unit members or Classified Supervisors who add their Spouse after April 30, 2010 will pay a higher rate contribution to include their spouse for Health Coverage. * OAPSE bargaining unit members or Classified Supervisors as of April 30, 2010, so long as they are continuously employed by the Board, shall be entitled to enroll a spouse for primary coverage at these rates if a qualifying event occurs. * OAPSE bargaining unit members or Classified Supervisors as of April 30, 2010, who have continuously covered their spouse on their health coverage since April 30, 2010, shall be allowed to continue Spousal coverage at these lower rates during their continuous employment with the district.

Medical

26 Pay Plan	Select Basic	Select	Choice
Employee only	9.47	18.53	42.54
Employee + one *	18.89	36.96	84.82
Family *	27.87	54.53	125.15
Employee + one **(Including Spouse)**	188.52	206.60	254.46
Family **(Including Spouse)**	278.16	304.82	375.43
Family (4 hour employee)	771.33	797.99	868.61

* OAPSE bargaining unit members or Classified Supervisors who add their Spouse after April 30, 2010 will pay a higher rate contribution to include their spouse for Health Coverage.

* OAPSE bargaining unit members or Classified Supervisors as of April 30, 2010, so long as they are continuously employed by the Board, shall be entitled to enroll a spouse for primary coverage at these rates if a qualifying event occurs. * OAPSE bargaining unit members or Classified Supervisors as of April 30, 2010, who have continuously covered their spouse on their health coverage since April 30, 2010, shall be allowed to continue Spousal coverage at these lower rates during their continuous employment with the district.

Dental

	21 Pay Plan	26 Pay Plan
Employee only	4.05	3.27
Family	4.05	3.27

Supplemental Life Insurance

21 Pay Plan	2.94
26 Pay Plan	2.38

Vision Care is fully paid for by Columbus City Schools

COLUMBUS CITY SCHOOLS

2018 Employee Contributions for Benefits

Eligible Tutors

Medical

21 Pay Plan		
Tutors (15-25 hours)	**Select**	**Choice**
Employee only	220.80	228.96
Employee plus one (Child or Spouse)	440.28	456.54
Family (Child or Spouse)	649.59	673.58
Tutors (Over 25 hours)	**Select**	**Choice**
Employee only	125.77	133.93
Employee plus one (Child or Spouse)	250.77	267.03
Family (Child or Spouse)	369.99	393.99

26 Pay Plan		
Tutors (15-25 hours)	**Select**	**Choice**
Employee only	178.34	184.93
Employee plus one (Child or Spouse)	355.61	368.74
Family (Child or Spouse)	524.67	544.05
Tutors (Over 25 hours)	**Select**	**Choice**
Employee only	101.58	108.17
Employee plus one (Child or Spouse)	202.55	215.68
Family (Child or Spouse)	298.84	318.22

Dental

	21 Pay Plan	26 Pay Plan
Employee Only (15-25 hours)	20.22	16.33
Family (15-25 hours)	20.22	16.33
Employee Only (over 25 hours)	11.33	9.15
Family (over 25 hours)	11.33	9.15

Vision Care is fully paid for by Columbus City Schools

Tutors are not eligible for Supplemental Life Insurance

COLUMBUS CITY SCHOOLS

Latchkey Teachers

2018 Employee Contributions for Benefits

Medical

21 Pay Plan	Select	Choice
Employee only	125.77	133.93
Employee plus one (Child or Spouse)	250.77	267.03
Family (Child or Spouse)	369.99	393.99

Medical

26 Pay Plan	Select	Choice
Employee only	101.58	108.17
Employee plus one (Child or Spouse)	202.55	215.68
Family (Child or Spouse)	298.84	318.22

Dental

	21 Pay Plan	26 Pay Plan
Employee only	11.33	9.15
Family	11.33	9.15

Vision

21 Pay Plan	1.31
26 Pay Plan	1.06

Latchkey Teachers are not eligible for Supplemental Life

COLUMBUS CITY SCHOOLS

Job Share Teachers

2018 Employee Contributions for Benefits

Medical

21 Pay Plan	Select		Choice
Job Share Percentage	**50%**		**50%**
Employee only	242.39		250.55
Employee plus one (Spouse on CCS coverage as of June 1, 2009, or Child)*	483.33		499.59
Employee plus one **(Including Spouse)**	569.47		585.73
Family (Spouse on CCS coverage as of June 1, 2009, and/or Children)*	713.13		737.13
Family **(Including Spouse)**	840.22		864.21

* CEA bargaining unit members or Administrators hired **after** May 31, 2009 will pay a higher rate contribution to include their spouse for Health Coverage. * CEA bargaining unit members or Administrators as of May 31, 2009, so long as they are continuously employed by the Board, shall be entitled to enroll a spouse for primary coverage at these rates if a qualifying event occurs. * CEA bargaining unit members or Administrators as of May 31, 2009, who have continuously covered their spouse on their health coverage since May 31, 2009, shall be allowed to continue Spousal coverage at these lower rates during their continuous employment with the district.

Medical

26 Pay Plan	Select		Choice
Job Share Percentage	**50%**		**50%**
Employee only	195.78		202.37
Employee plus one (Spouse on CCS coverage as of June 1, 2009, or Child)*	390.38		403.51
Employee plus one **(Including Spouse)**	459.96		473.09
Family (Spouse on CCS coverage as of June 1, 2009, and/or Children)*	575.99		595.37
Family **(Including Spouse)**	678.64		698.02

* CEA bargaining unit members or Administrators hired **after** May 31, 2009 will pay a higher rate contribution to include their spouse for Health Coverage. * CEA bargaining unit members or Administrators as of May 31, 2009, so long as they are continuously employed by the Board, shall be entitled to enroll a spouse for primary coverage at these rates if a qualifying event occurs. * CEA bargaining unit members or Administrators as of May 31, 2009, who have continuously covered their spouse on their health coverage since May 31, 2009, shall be allowed to continue Spousal coverage at these lower rates during their continuous employment with the district.

Dental Coverage			Vision Coverage	
Job Share Percentage	**50%**		**Job Share Percentage**	**50%**
21 Pay - Employee only	22.25		**21 Pay -** Employee only	2.34
21 Pay - Family Coverage	22.25		**21 Pay -** Family Coverage	2.34
26 Pay - Employee only	17.97		**26 Pay -** Employee only	1.89
26 Pay - Family Coverage	17.97		**26 Pay -** Family Coverage	1.89

Supplemental Life Insurance ($25,000)

21 Pay Plan	2.94
26 Pay Plan	2.38

Basic Term Life Insurance - MetLife

Planning for your family's financial well-being can bring you peace of mind. Life Insurance can provide financial support to your beneficiaries in the event of your death. Your employer pays the full cost of your Basic Term Life Insurance coverage through MetLife. You may purchase additional coverage to meet your needs. For more life insurance options in addition to the Supplemental Life Insurance described in the next column, please see the section of this guide on the Universal Life Insurance Plan (page 23) or Group Term to Age 100 (page 26).

Your Coverage

You may choose from among the following options for Life Insurance coverage:

- Basic Life Insurance - term life insurance paid for in full by your employer and based on your position
- Supplemental Life Insurance - If eligible, you may elect to purchase additional term life insurance coverage for yourself in amounts based on your position

Basic Life Insurance Amounts

- Full-time teachers and administrators received $50,000 in Basic Life Coverage
- Half-time teachers receive $25,000 in Basic Life coverage
- Full-time classified employees receive $50,000 in Basic Life coverage
- Half-time classified employees receive $25,000 in Basic
- Life coverage
- Eligible tutors receive $20,000 in Basic Life Insurance coverage

Please note that Latchkey teachers are not eligible for Basic Life coverage.

Supplemental Life Insurance

If you are a teacher, administrator, or classified employee, you may purchase Supplemental Life Insurance equal to your Basic Life Insurance amount. **Please note that tutors and latchkey teachers are not eligible to elect Supplemental Life Insurance.**

Whether you are enrolling as a new employee or during Open Enrollment, no proof of good health is required.

You pay for your Supplemental Life Insurance coverage with post-tax dollars through convenient payroll deduction.

Please Confirm Your Beneficiary Information in ESS

Please be sure to verify that your beneficiary's information is correct in ESS during Open Enrollment.

If you are changing your beneficiary, or are enrolling for the first time, you will be required to enter your beneficiaries' birthdates (MM/DD/YYYY) and their Social Security numbers, along with the percentage (%) of insurance you wish to designate for that individual. Your beneficiary will be the same for your Basic and Supplemental Life Insurance policies.

Why is having enough Life Insurance protection important?

Because you'd want your loved ones to be able to meet financial obligations if something would happen to you prematurely.

If you have a spouse and/or children, they may rely on you to help keep the household running. One-third of surviving spouses surveyed do not feel at all financially secure in the year following their spouse's death, and many used life insurance proceeds to meet basic needs. It is important to take steps to make sure your family would be financially prepared if you were no longer there to handle expenses like:

- Mortgage or rent payments
- Insurance premiums
- Transportation
- Utilities
- Food
- Child care/education fees

Covering everyday living expenses and household bills is just one part of the life insurance equation. Without enough life insurance coverage, a premature death is more likely to exert a major or devastating impact on financial security, lifestyle and savings. Many families would probably have trouble keeping up with longer term expenses like:

- College Tuition
- Wedding Expenses
- Child or aging parent care
- Retirement

This plan also includes access to MetLife Advantages a comprehensive suite of valuable services for support, planning and protection needs, such as:

- **Will Preparation Services -** Offers you and your spouse face-to-face meetings with an attorney to prepare a will, living will or power of attorney for you and your spouse.
- **MetLife Estate Resolution Services** - Estate representatives and beneficiaries may receive face-to-face legal representation with probating your estate and your spouse's estates. Beneficiaries can also consult a participating plan attorney for general questions about the probate process.
- **Portability -** Gives you an opportunity to continue your Supplemental Group Term Life insurance coverage with MetLife if you retire or leave the company.
- **Grief Counseling -** Provides you and your dependents up to five face-to-face counseling sessions per event with a professional grief Specialistto help cope with a loss, major life event or a serious medical condition.

These services are included in your plan at no additional cost to you!

Flexible Spending Accounts

As part of the wide range of choices the Columbus City Schools benefits program offers, you may also elect to set up a Flexible Spending Account to help save income taxes on predictable eligible health and/or dependent care expenses.

You may choose to set up either or both:

- A Health Care Flexible Spending Account
- A Dependent Care Flexible Spending Account

How a Flexible Spending Account Works

Here's how a Flexible Spending Account works:

For the Health Care Flexible Spending Account:

- Estimate how much you expect to spend on eligible health care expenses for the plan year (January 1, 2018 through December 31, 2018). Consider medical, dental, vision and hearing expenses not covered by the benefit plans, such as copays and deductibles, as well as other eligible expenses. The maximum contribution you may elect is $2,500 per plan year. The minimum contribution is $260 per plan year (26 pay).

- Throughout 2018, you will use the Discovery Benefit card to pay for eligible expenses. **Please be advised the IRS guidelines require you to be able to provide documentation verifying your expenses.** If you are unable to provide the requested information, your debit card may be frozen preventing you from using it. At the close of the plan year, any unsubstantiated claims must be repaid.

- For eligible FSA expenses where MasterCard is not accepted, pay out of your own pocket and submit a claim for reimbursement, with a copy of any necessary documents (receipts, explanation of benefits, etc.) to Discovery Benefits at the address listed on the claim form available on their website www.discoverybenefits.com. NOTE: Refer to Qualifying Expenses in the next column.

For the Dependent Care Flexible Spending Account

- Estimate your eligible expenses for dependent day care while you work, or other dependent care expenses. The maximum you may elect is based on your tax filing status: $5,000 (if you are single or married and filing a joint return) or $2,500 (if you are married and filing a separate return).

- Pay for eligible dependent care expenses out of your own pocket and submit a claim for reimbursement, with a copy of any necessary documents (receipts, etc.) to Discovery Benefits at the address listed on the claim form available on their website www.discoverybenefits.com.

- Reimbursements are processed daily and your reimbursement will be sent according to your choice of direct deposit or check.

- **You must re-enroll in FSAs every year,** as your enrollment cannot be carried over. You may make your elections:

⇒ During Open Enrollment
⇒ Within 30 days of when you become eligible
⇒ Within 30 days of when you have a qualifying event (Job or Life Status Change)

Please visit the CCS Benefits webpage at ccsoh.us/Staff/2018 Employee Benefits and take advantage of our partnership with the FSA Store for your health care needs.

Qualifying Expenses

Health Care Flexible Spending Account

Any health care expenses qualifying under the Internal Revenue Code for income tax purposes also qualify for reimbursement through the Health Care Flexible Spending Account. If you use the account for these expenses, you cannot take an income tax deduction as well. Eligible expenses include, but are not limited to:

- Deductibles, co-insurance and copays – for medical, dental, pharmacy and vision care;
- Amounts you pay in excess of plan limitations for Usual, Customary and Reasonable (UCR) charges;
- Amounts in excess of annual or lifetime benefit maximums; and
- Expenses not covered or not fully covered by your Plan

NOTE: Over-the-counter medications without a prescription (except insulin) are not eligible for reimbursement through the Flexible Spending Account.

Dependent Care Flexible Spending Account

Any expenses qualifying for a Federal Child and Dependent Care Tax Credit for income tax purposes also qualify for reimbursement through the Dependent Care Flexible Spending Account.

If you use the account to reimburse yourself for eligible expenses, you cannot take the Federal Tax Credit for the same expenses. Eligible expenses include those services provided inside or outside your home while you work by anyone other than your spouse or your dependents to care for eligible dependent children (under age 13) or dependents who are physically or mentally unable to care for themselves for whom you contribute more than half of their support.

General Plan Rules

The Internal Revenue Service imposes the following rules and regulations on pre-tax Flexible Spending Accounts:

- Under plan guidelines for the Health Care Flexible Spending Account, employees have up until March 15, 2018 to continue to incur medical expenses and use funds that they have not exhausted from their 2017 accounts. For example, you can go to the dentist in February 2018, get a root canal and use money set aside between January 1 and December 31, 2017 to pay for this expense with a date of service in February 2018. The grace period described above does not apply to funds in the Dependent Care account.
- The IRS allows you to continue to be reimbursed money left in both your Dependent and Health Care Flexible Spending Accounts from 2017. All submissions for reimbursement for the 2017 Dependent and Health Care Flexible Spending Accounts are due to Discovery Benefits no later than **April 30, 2018. Any dollars in Flexible Spending Accounts left unclaimed after the April 30th deadline will be forfeited.**
- You may be eligible for a Federal Child and Dependent Care Tax Credit and/or to deduct certain health care expenses on your tax return. Be sure to talk to a tax advisor to see whether the tax credits and deductions or the Flexible Spending Accounts are the best choice for you.
- For the Health Care Flexible Spending Account, you can be reimbursed up to the full amount you elect to contribute for the plan year even if funds are not yet deposited into your account. However, you can only be reimbursed up to the amount deposited into your Dependent Care Flexible Spending Account at the time of your claim.
- You cannot use money in your Health Care Flexible Spending Account to be reimbursed for dependent day care expenses and you cannot use money in your Dependent Care Flexible Spending Account to be reimbursed for health care expenses. You also cannot transfer money from one account to the other.

Flexible Spending Accounts and ESS

When entering your 2018 election amount for your Flexible Spending Account(s), you will need to enter the bi-weekly amount that you want taken out of your paycheck in the amount field in ESS. For example, if you want to elect a $1,000 annual amount for the Health Care FSA, you will need to enter $38.46 (for 26 pays) or $47.62 (for 21 pays). Once you make your bi-weekly election, your annual amount will also appear on your main benefit screen under your current election.

Employee Assistance Plan - Guidance Resources

The Employee Assistance Program (EAP) provides confidential, professional assistance and valuable resources to you and members of your family to help resolve any issue that interferes with your daily life. The EAP covers up to four (4) visits per issue per member.

In emergencies, a specialist can be reached by telephone 24 hours a day, seven days a week. The services have been prepaid by Columbus City Schools so there is no cost to you or your immediate family when you need help.

To arrange a confidential appointment with a specialist near you, call Guidance Resources. Appointments can be scheduled during the day or evenings, Monday through Saturday. You can consult with a specialist in a face-to-face meeting or, if you prefer, a telephone appointment can be scheduled. A session is normally 50 minutes in length.

Frequently Asked EAP Questions

How can my EAP help me or my family member?

EAP specialists have professional training and expertise in a wide range of issues, including:

- Relationship & family problems
- Depression
- Alcohol & drug abuse
- Emotional & psychological concerns
- Financial & legal difficulties
- Daily living information
- Stress & much more

How do I or my family member use the EAP?

Just pick up the phone and call Guidance Resources at 1-800-774-6420, available 24/7. A specialist will help you decide on your best course of action. You can also access information about the EAP by going online to www.guidanceresources.com.

Who will know about my problems?

This program is built on confidentiality. All discussions between employees and the EAP are kept private, unless you consent in writing to reveal your conversations, or as mandated by law.

Eligible Expenses for Flexible Spending

To learn more about which expenses are eligible under the Flexible Spending Accounts, you can find lists of eligible expenses in IRS Publications 502 and 503. Please visit the IRS Website at www.irs.gov/publications.

Voluntary Benefit Choices

About Voluntary Benefits

Voluntary benefits are additional insurance products available for purchase at affordable rates. You also have the advantage of paying for these benefits through convenient, after-tax, payroll deductions.

As a new employee, you may purchase many of these coverages without a medical exam. Proof of good health will be required if an existing employee or dependent enrolls at any later time. Furthermore, since you purchase these plans individually, many can be continued should you terminate employment with the school system.

How to Enroll

During Open Enrollment, you can enroll in Voluntary Benefits when you meet with a Benefits Specialist who can answer your questions and provide you with rates for these insurance options. You can also enroll by visiting https://bentecworkplace.com/columbus to schedule a co-browsing session with a Benefits Specialist. See Page 4 for instructions. New employees will need to call BenTec at 800-735-0080 within 30 days of employment to schedule a Voluntary Benefits enrollment session.

NOTE: Regarding Voluntary Benefits:
Proof of good health may be required for enrollment.

Universal Life with Living Benefits

Universal Life Insurance is permanent insurance that builds cash value. The Universal Life Insurance plan is made available through Trustmark Insurance Company. If you leave your employment, you may continue coverage through Trustmark Insurance Company.

Insurance for Yourself

You may purchase Universal Life Insurance for yourself in $5,000 increments, up to a maximum of $300,000. As a new employee, you may enroll for the lesser of $14 per week up to $200,000 (maximum age 64) without proof of good health. Later enrollments will not require proof of good health for the lesser of $10 per week up to $200,000. At your death, the plan pays a benefit to your beneficiary. An Accidental Death Benefit doubles the death benefit if death occurs by accident prior to age 75.

Insurance for Your Dependents

You may also elect insurance for your spouse. For your spouse, you may choose the greater of $5,000 or an amount purchased with a premium of $3 per week. Premiums are based on your spouse's age.

In addition, you may cover each eligible child for $5,000 or $10,000 through an optional Child Term Rider.

Built-In Long Term Care Benefits

The Universal Life Insurance plan has a Long Term Care Benefit to help you pay for medically necessary Long Term Care services or confinement. To qualify, you must meet the plan's requirements for assistance with Activities of Daily Living or suffer from a Cognitive Impairment.

Long Term Care Benefit is 4% of the death benefit per month for up to 25 months for Activities of Daily Living assistance provided by a:

- Nursing Home
- Assisted Living Facility
- Adult Day Care
- Home Health Care

There is a 90-day elimination (waiting) period before Long Term Care Benefits can be paid. A built-in rider (Benefit Restoration Rider) automatically restores the death benefit that is reduced to pay for Long Term Care, so your family receives a full death benefit when they need it most.

Living Benefits

Living Benefits allow you to advance part of your death benefit to help you cover current financial needs for terminal illness, in addition to the long term care feature described above.

Plan Costs

You pay for your Universal Life Insurance coverage and any coverage you choose for your spouse or children through convenient post-tax payroll deduction.

Your premium is based on your age, the coverage amount you select and whether or not you smoke. For cost information, ask your Benefit Specialistwhen you enroll.

Plan UL205 is underwritten by Trustmark Insurance Company, Lake Forest, Illinois.

Optional Riders

- An optional rider extends the Long Term Care benefit up to an additional 25 months.
- You may also choose the EZ Value automatic increase option, which adds and additional $1 weekly deduction each year for 10 years. This will increase your coverage regardless of future insurability.

EZ Value Plan Option For Employees

The EZ Value Plan feature is a future guaranteed insurability option which automatically increases coverage annually on each of the first five or ten policy anniversaries. The amount of Death Benefit increase is equal to the amount of protection an additional $1.00 per week deduction will purchase. For more information about this feature, ask your Benefits Specialist.

Short Term Disability Option

Your ability to provide an income for your family is your most important asset. If you are sick or injured and can't work, you need a way to replace lost income. If you wish, you may elect a voluntary Short Term Disability (STD) benefit plan. This plan is made available through Trustmark Insurance Company. This plan is designed to replace a portion of your income during disability due to illness or injuries lasting more than 14 days. During any absence of less than 14 days, you will be required to use any sick leave benefits you may have.

How the Plan Works

When you have a qualifying total disability*, you must first satisfy a 14-day elimination period before the plan will begin paying benefits. While using your sick leave (which is required even if you enroll for Short Term Disability), you may receive up to 60% of your earnings, to a maximum of $1,350 per week, in addition to your sick leave pay. Once your sick leave is exhausted, you will continue to receive up to 60% of your eligible earnings, up to $1,350 per week from the STD plan. As long as you qualify, benefits are payable for up to 26 weeks. Your premium is waived for you if you remain disabled for 90 consecutive days during the benefit period.

*A qualifying total disability means that, because of a non-work-related sickness or injury, you are unable to do the substantial and material duties of your regular job and you are not doing any work for pay or benefits. You must be under the care of a physician to receive benefits. Benefits are not payable for pre-existing conditions during the first 12 months of coverage for diagnoses three months prior to your effective date.

If you have questions about the Short Term Disability coverage, ask your Benefits Specialist when you enroll.

Plan Costs

You pay for the Short Term Disability plan through convenient payroll deduction. For cost information, ask your Benefits Specialist when you enroll.

Make sure to update your Short Term Disability policies to reflect salary changes.

Plan VGD-404 is underwritten by Trustmark Insurance Company, Lake Forest, Illinois.

Accident Option

What is Accident Insurance?

Accident Insurance pays you benefits for specific injuries and events resulting from a covered accident that occurs on or after your coverage effective date. The benefit amount depends on the type of injury and care received. Accident Insurance is a limited benefit policy. It is not health insurance and does not satisfy the requirement of minimum essential coverage under the Affordable Care Act.

Features of Accident Insurance include:

- Guaranteed Issue : No medical questions or tests are required for coverage
- Flexible – You can use the benefit payments for any purpose you like
- Portable – If you leave your current employer or retire, you can take your coverage with you.

How can Accident Insurance Help?

Below are a few examples of how your Accident Insurance benefits could be used:

- Medical expenses, such as deductibles and copays
- Home healthcare costs
- Lost income due to lost time at work
- Everyday expenses like utilities and groceries

What accident benefits are available?

The following list is a summary of the benefits provided by Accident Insurance. You may be required to seek care for your injury within a set amount of time. Note there may be some variations by state.

- **Accident Hospital Care:** Surgery (open abdominal, thoracic, Surgery (exploratory or without repair), Blood, Plasma, Platelets, Hospital admission, Hospital Confinement (per day, up to 365 days), Critical Care Unit Confinement (per day, up to 15 days), Coma (duration of 14 or more days), Transportation (per trip, up to three per accident), Lodging (per day, up to 30 days)
- **Accident Care:** Initial doctor visit, Urgent care facility treatment, Emergency room treatment, Ground ambulance, Air ambulance, Follow-up doctor treatment, Medical equipment, Physical or occupational therapy (up to six per accident), Prosthetic device , Outpatient surgery (one per accident), X-ray
- **Dislocations:** Hip joint, Knee, Ankle or foot bone, Shoulder, Elbow, Wrist, Finger/toe, Hand bones, Lower jaw, Collarbone, Partial dislocations
- **Fractures:** Hip, Leg, Ankle, Kneecap, Foot (excluding toes, heels), Upper arm, Forearm, Hand, Wrist, Finger, Toe, Vertebral body, Vertebral processes, Pelvis, Coccyx, Bones of face, Nose, Upper jaw, Lower jaw, Collarbone, Rib or ribs, Skull (simple and depressed), Sternum, Shoulder blade, Chip fractures
- **Common injuries**: Burns, Skin grafts, Emergency dental work, Eye injury, Torn knee cartilage, Laceration*, Ruptured disk, Tendon/ligament/rotator cuff, Concussion, Paralysis,
- **Wellness Benefit:** $100 for employee & spouse per year for completing a health screening test, $50 for each child up to a maximum of $200 per year for all children
- **Accidental Death & Dismemberment**
- **Catastrophic Accident Benefits**

This is a summary of benefits only. A complete description of benefits, limitations, exclusions and termination of coverage will be provided in the certificate of insurance and riders. All coverage is subject to the terms and conditions of the group policy. If there is any discrepancy between this document and the group policy documents, the policy documents will govern. Accident Insurance is underwritten by ReliaStar Life Insurance Company (Minneapolis, MN) a member of the Voya family of companies.

Critical Illness Option

What is Critical Illness Insurance?

Critical Illness Insurance pays a lump-sum benefit if you are diagnosed with a covered illness or condition on or after your coverage effective date. You have the option to elect Critical Illness Insurance to meet your needs. Critical Illness Insurance is a limited benefit policy. It is not health insurance and does not satisfy the requirement of minimum essential coverage under the Affordable Care Act.

Features of Critical Illness Insurance Include:

- Guaranteed Issue: No medical questions or tests are required for coverage
- Flexible: You can use the benefit payments for any purpose you like
- Payroll deductions: Premiums are paid through convenient payroll deductions
- Portable: If you leave your current employer or retire, you can take your coverage with you

For what critical illnesses and conditions are benefits available?

Critical Illness Insurance provides a benefit payment for the following illnesses and conditions. Covered illnesses/conditions are broken out into groups called "modules". Benefits are paid at 100% of the Maximum Critical Illness Benefit amount unless otherwise stated. For a complete description of your benefits, along with applicable provisions, conditions on benefit determination, exclusions and limitations, see your certificate of insurance and any riders.

- **Base Module:** Heart attack (Cardiac arrest is not a heart attack), Stroke, Coronary artery bypass (25%), Coma, Major organ failure, Permanent paralysis, End state renal (kidney) failure
- **Cancer Module:** Cancer, Skin cancer (10%), Carcinoma in situ (25%)

How can Critical Illness Insurance help?

Below are a few examples of how your Critical Illness Insurance benefit could be used (coverage amounts may vary):

- Medical expenses, such as deductible and copays
- Child care
- Home healthcare costs
- Mortgage payment/rent and home maintenance

What Maximum Critical Illness Benefit am I eligible for?

- For employees: You have the opportunity to purchase a Maximum Critical Illness Benefit of $30,000 in $5,000 increments
- For your spouse:: You have the opportunity to purchase a Maximum Critical Illness Benefit of $15,000 in $5,000 increments. Employee must elect coverage.
- For your children: You have the opportunity to purchase a Maximum Critical Illness Benefit of $10,000 or $1,000, $2,500, $5,000 for each covered child. Employee must elect coverage.

How many times can I receive the Maximum Critical Illness Benefit?

Usually you are only able to receive the Maximum Critical Illness Benefit once for each covered condition. Your plan includes the Recurrence Benefit (this benefit does not apply to the cancer module), which allows you to receive a benefit for the same condition a second time. It's important to note that in order for the second occurrence of the illness to be covered, it must occur after 6 consecutive months without the occurrence of any covered critical illness named in your certificate, including the illness form the first benefit payment.

If you have reached the benefit limit by receiving the maximum benefit for each covered condition, you may choose to end our coverage; however, if you have coverage for your spouse and/or children, you must continue your coverage in order to keep their coverage active. Please see your certificate of coverage for details.

What does my Critical Illness Insurance include?

- **Wellness Benefit:** This provides an annual benefit payment if you complete a health screening test. You may only receive a benefit payment once per year, even if you complete multiple health screening tests.
  - Examples of health screening tests include but are not limited to: Pap test, serum cholesterol test for HDL & LDL levels, mammography, colonoscopy and stress test on bicycle or treadmill.
  - The annual benefit amount is $100 for completing a health screening test.
  - If your spouse and/or children are covered for Critical Illness Insurance, they are also covered by the Wellness Benefit. Your spouse's benefit amount is also $100. The benefit for child coverage is 50% of your benefit amount per child with an annual maximum of $200 for all children.

**This is a summary of benefits only. A complete description of benefits, limitations, exclusions and termination of coverage will be provided in the certificate of insurance and riders. All coverage is subject to the terms and conditions of the group policy. If there is any discrepancy between this document and the group policy documents, the policy documents will govern. Critical Illness Insurance is underwritten by ReliaStar Life Insurance Company (Minneapolis, MN) a member of the Voya family of companies.*

Group Term to Age 100 Option

Life is unpredictable. You don't know when or how you will die, but having the right coverage in place can provide peace of mind for you and your family. Group Term to Age 100 Life Insurance provides a lump-sum cash benefit should you or your covered spouse or dependents die before the age 100. The death benefit is guaranteed for the first five years of coverage and priced so the benefit can remain level under current experience factors. The tax-free* death benefit is paid directly to your designated beneficiary in one lump-sum and can be used to help cover daily living expenses, debts, funeral costs and more.

**With proper planning, the death benefit can pass to your beneficiaries free from state or federal estate taxes. Please consult with your tax advisor for specific information.*

The supplemental health coverage is provided by limited benefit insurance. *The policies have exclusions and limitations, may have reductions of benefits at specific ages, and may not be available for sale in all states. The policies are underwritten by American Heritage Life Insurance Company (Home Office: Jacksonville, FL). For costs and complete details contact your Allstate Benefits Representative. Allstate Benefits is the marketing name for American Heritage Life Insurance Company, a subsidiary of The Allstate Corporation.*

Legal Insurance Option (non-CEA members only)

The LegalGUARD Plan, through LegalEASE, offers a package of legal assistance benefits that can help you deal with a variety of legal situations. This service is available through a convenient post-tax payroll deduction.

The LegalGUARD Plan includes the following benefits:

- Unlimited free consultations with Plan Attorneys in person, over the phone, or online;
- Wide range of legal documents including deeds, leases, affidavits and others;
- Members may have a free Simple Will and Power of Attorney prepared by a Plan Attorney each year;
- A Simple Divorce is paid in full;
- Many other Family law issues are also covered such as Child Support, Child Custody and Adoptions;
- Criminal Defense Matters; and
- Real Estate Matters and more.

Your LegalGUARD Plan also offers assistance with:

- Debit Management
- Financial Planning
- Budgeting
- Financial Counseling
- Identity Theft
- Prevention Identity
- Theft Recovery

Pet Insurance - VPI Pet Insurance

Similar to health insurance for the people in your family, the Pet Insurance Plan helps you meet the cost of caring for your pets. The Pet Insurance Plan is available through VPI Pet Insurance.

You may choose from several levels of benefits that cover some of the cost of routine care as well as treatment for injuries and illnesses.

Your cost for coverage is based on your pet's age and breed. You pay for the coverage through a convenient post-tax payroll deduction.

To learn more about Pet Insurance please visit their web site at www.petinsurance.com. Benefits Specialists will not be able to enroll employees for Pet Insurance.

Summary of Benefits and Coverage (SBC)

As part of the Patient Protection and Affordable Care Act (Health Care Reform), all employees are to have access to a Summary of Benefits and Coverage (SBC). To view electronically, please visit the CCS Benefits webpage available at ccsoh.us/Staff/2018 Employee Benefits.

Employees may also pick up a printed copy of this information in the Employee Benefits Department.

Other Information

Consolidated Omnibus Budget Reconciliation Act (COBRA)

COBRA, a federal law, allows insured employees and their dependents to continue health and dental coverage under several circumstances when it would normally be lost.

Below is the basis for COBRA continuation:

1. Loss of Employment (resignation/termination) – If an employee terminates employment, the employee and/or insured dependents may continue his/her health coverage for up to 18 months.

2. Reduction of Hours – If any employee's hours of

employment are reduced so that he/she is no longer entitled to benefits, he/she and/or insured dependents may continue health coverage for up to 18 months (includes unpaid leave

of absence or personal leave).

3. Death of Employee – If an employee with dependent coverage should die, covered dependents may continue their health coverage for up to 36 months.

4. Loss of Dependent Eligibility – Health coverage may be continued

for a child who was covered by dependent coverage and has reached the age limitation for normal coverage, for up to 36 months.

5. Divorce – If an employee and his/her spouse are divorced, and the spouse and/or other dependents were covered as dependents on the employee's health insurance, the divorced spouse and/or dependents may continue his/her health coverage for up to 36 months.

6. Extension for Disabled Persons – If a person is totally disabled for social security purposes at the time that one of the reasons listed in (1) or (2) above occurs, that person is entitled to up to 29 months of continued health coverage.

Premiums for the above insurance are paid by the person using COBRA coverage. If one of the above events occurs, please contact Employee Benefits so that COBRA can be offered. Employees have 60 days from the qualifying event to complete and return the COBRA application or forfeit any rights to continuation of coverage.

HR Administration
Benefits Department
270 East State Street

Important Notice from Columbus City Schools about Your Prescription Drug Coverage and Medicare for Plan Year 2018

Please read this notice carefully and keep a copy for your records.

This notice provides important information about your current prescription drug coverage through Columbus City Schools and about your options under Medicare's prescription drug coverage (if you are currently eligible for Medicare). 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.

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.Columbus City Schools has determined that the prescription drug coverage offered by the Columbus City Schools Health 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 through December 7th. However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?
If you decide to join a Medicare drug plan, your current Columbus City Schools coverage will be affected. If you continue to be enrolled in the Columbus City Schools health plan, your benefits will coordinate with Medicare Part D. If you do not enroll in Columbus City Schools plan, you will lose both your medical and prescription drug coverage. If you do decide to join a Medicare drug plan and drop your current Columbus City Schools coverage, be aware that you and your dependents can re-enroll during the annual Open Enrollment period.

When Will You Pay a Higher Premium (Penalty) to Join a Medicare Drug Plan?
You should also know that if you drop or lose your current coverage with Columbus City Schools and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (penalty) to join a Medicare drug plan later.

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

as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

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

Contact the Benefits Department at 365-6475 with any questions you might have about the CCS pharmacy benefit plan.

- Contact Express Scripts at 866-533-7005 with any questions regarding your current prescription drug coverage
- Note: You'll get this notice each year before the next period you can join a Medicare drug plan and if this coverage through Columbus City Schools changes. You may also request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

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

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

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

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, 2016. Contact your State for more information on eligibility –

ALABAMA – Medicaid	FLORIDA – Medicaid
Website: http://myalhipp.com/	Website: http://flmedicaidtplrecovery.com/hipp/
ALASKA – Medicaid	**GEORGIA – Medicaid**
The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx	Website: http://dch.georgia.gov/medicaid - Click on Health Insurance Premium Payment (HIPP) Phone: 404-656-4507
ARKANSAS – Medicaid	**INDIANA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Healthy Indiana Plan for low-income adults 19-64 Website: http://www.hip.in.gov Phone: 1-877-438-4479 All other Medicaid Website: http://www.indianamedicaid.com
COLORADO – Medicaid	**IOWA – Medicaid**
Medicaid Website: http://www.colorado.gov/hcpf Medicaid Customer Contact Center: 1-800-221-3943	Website: http://www.dhs.state.ia.us/hipp/ Phone: 1-888-346-9562

KANSAS – Medicaid	NEW HAMPSHIRE – Medicaid
Website: http://www.kdheks.gov/hcf/ Phone: 1-785-296-3512	Website: http://www.dhhs.nh.gov/oii/documents/hippapp.pdf
KENTUCKY – Medicaid	**NEW JERSEY – Medicaid and CHIP**
Website: http://chfs.ky.gov/dms/default.htm Phone: 1-800-635-2570	Medicaid Website: http://www.state.nj.us/humanservices/ dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html
LOUISIANA – Medicaid	**NEW YORK – Medicaid**
Website: http://dhh.louisiana.gov/index.cfm/subhome/1/n/331 Phone: 1-888-695-2447	Website: http://www.nyhealth.gov/health_care/medicaid/ Phone: 1-800-541-2831
MAINE – Medicaid	**NORTH CAROLINA – Medicaid**
Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html Phone: 1-800-442-6003	Website: http://www.ncdhhs.gov/dma Phone: 919-855-4100
MASSACHUSETTS – Medicaid and CHIP	**NORTH DAKOTA – Medicaid**
Website: http://www.mass.gov/MassHealth Phone: 1-800-462-1120	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/
MINNESOTA – Medicaid	**OKLAHOMA – Medicaid and CHIP**
Website: http://mn.gov/dhs/ma/ Phone: 1-800-657-3739	Website: http://www.insureoklahoma.org Phone: 1-888-365-3742
MISSOURI – Medicaid	**OREGON – Medicaid**
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html
MONTANA – Medicaid	**PENNSYLVANIA – Medicaid**
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP	Website: http://www.dhs.pa.gov/hipp Phone: 1-800-692-7462

NEBRASKA – Medicaid	RHODE ISLAND – Medicaid
Website: http://dhhs.ne.gov/Children_Family_Services/AccessNebraska/Pages/accessnebraska_index.aspx	Website: http://www.eohhs.ri.gov/ Phone: 401-462-5300
NEVADA – Medicaid	**SOUTH CAROLINA – Medicaid**
Medicaid Website: http://dwss.nv.gov/ Medicaid Phone: 1-800-992-0900	Website: http://www.scdhhs.gov Phone: 1-888-549-0820
SOUTH DAKOTA - Medicaid	**WASHINGTON – Medicaid**
Website: http://dss.sd.gov Phone: 1-888-828-0059	Website: http://www.hca.wa.gov/free-or-low-cost-health-care/program-administration/premium-payment-program Phone: 1-800-562-3022 ext. 15473
TEXAS – Medicaid	**WEST VIRGINIA – Medicaid**
Website: http://gethipptexas.com/ Phone: 1-800-440-0493	Website: http://www.dhhr.wv.gov/bms/Medicaid%20Expansion/Pages/default.aspx
UTAH – Medicaid and CHIP	**WISCONSIN – Medicaid and CHIP**
Website: Medicaid: http://health.utah.gov/medicaid CHIP: http://health.utah.gov/chip Phone: 1-877-543-7669	Website: https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf Phone: 1-800-362-3002
VERMONT– Medicaid	**WYOMING – Medicaid**
Website: http://www.greenmountaincare.org/	Website: https://wyequalitycare.acs-inc.com/
VIRGINIA – Medicaid and CHIP	
Medicaid Website: http://www.coverva.org/programs_premium_assistance.cfm Medicaid Phone: 1-800-432-5924 CHIP Website: http://www.coverva.org/programs_premium_assistance.cfm CHIP Phone: 1-855-242-8282	

To see if any other states have added a premium assistance program since July 31, 2016, or for more information on special enrollment rights, contact either:

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

Paperwork Reduction Act Statement

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

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

OMB Control Number 1210-0137 (expires 10/31/2018)

The Newborns' and Mothers' Health Protection Act of 1996 (Newborn's Act)

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

Woman's Health and Cancer Rights Act of 1988 - Notice of Post-Mastectomy Benefits

The Women's Health and Cancer Rights Act of 1998, a federal law, was enacted on October 21, 1998. This law requires that a medical plan's coverage of a necessary mastectomy also include the following post-mastectomy coverage for:

- Reconstruction of the breast;
- Surgery of the other breast to achieve the appearance of symmetry;
- Prostheses; and
- Treatment of physical complications during any stage of the mastectomy, including lymphedemas.

This coverage will be provided in consultation with the attending physician and the patient. Benefits will be subject to the same annual deductibles, copays and coinsurance as applicable to any other type of care.

Special Enrollment Notice

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 coverage (or if the employer stops contributing toward you or your dependents' other coverage). However, you must request enrollment within 30 days after you or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

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.

Finally, you and your dependents may have special enrollment rights if coverage is lost under Medicaid or State health insurance ("SCHIP") program, or when you and/or your dependents gain eligibility for state premium assistance. You have 60 days from the occurrence of one of these events to notify the company and enroll in the plan.

To request special enrollment or obtain more information,

contact:

Courtney M. Hale

Address: 270 East State Street Columbus, OH 43215

Phone: 614-365-8610 Email: chale@columbus.k12.oh.us

COLUMBUS
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Please Note: This Benefits Guide highlights your benefits offered through the Columbus City Schools. Complete descriptions of the plans are contained in corresponding plan documents or insurance contracts. If there is any discrepancy between this benefits booklet and the wording of the corresponding plan document, the plan document or insurance documents will govern. This booklet does not constitute a contract to the extent permitted by law.


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