2019

EMPLOYEE BENEFITS ENROLLMENT GUIDE

Open Enrollment - October 9th-26th, 2018

COLUMBUS CITY SCHOOLS

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About This Booklet

This booklet has been designed to help you understand the Columbus City Schools Employee Benefits Program for plan year January 1, 2019 through December 31, 2019. It outlines all of the available benefit plans for you to help you choose the best possible combination of options for you and your family. Please read this booklet carefully and, if you have any questions not addressed in this guide, contact the Benefits Department at benefitquestions@columbus.k12.oh.us. Benefits information can also be found on the CCS Benefits webpage at https://www.ccsoh.us/employeebenefits.

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 Program (EAP)	Guidance Resources	1-800-774-6420	www.guidanceresources.com
Term to 100 Life	Allstate	1-800-521-3535	www.allstatebenefits.com/ mybenefits
Short Term Disability (STD)	Voya	1-866-228-8742	www.voya.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	USEBSG (formerly known as Bentec)	1-800-735-0080	https://ccs.mybenefitsinfo.com
CCS Benefit Department	Columbus City Schools	1-614-365-6475	https://www.ccsoh.us/ employeebenefits

How to Enroll

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

- Enroll in Benefits
- Reconfirm Current Benefits
- Make Changes
- Waive Benefits

Choose one of the four options to complete your Open Enrollment process:

1. Speak with a Benefits Specialist over the phone via the Enrollment Call Center

- Visit https://ccs.mybenefitsinfo.com
- Click on the Call Center option.
- Follow the prompts to select your appointment date/time between the hours of 10am and 6:30pm ET.
- You will receive a confirmation email, coming from a secure email address, with a phone number to the Call Center.
- The sessions are conducted over the phone. You must be able to access Employee Self Service (ESS) on a computer at the time of the appointment and be able to print a copy of your ESS confirmation statement for your records.
- During the co-browsing sessions, both you and the Benefit Specialist are able to see the same screen at the same time.

You are responsible for entering your core benefit elections into ESS with the assistance of the Benefits Specialist.

2. Meet with a Benefits Specialist in person at your location	3. Meet with a Benefits Specialist at a Computer Lab	4. Complete your own enrollment using ESS
To schedule a time, please visit: https://ccs.mybenefitsinfo.com Visit the website to select your desired location. Please follow the prompts to select your appointment date and time. *(Limited Availability)*	To schedule a time, please visit: https://ccs.mybenefitsinfo.com (Or feel free to walk-in) Visit the website to select your desired lab location. A Benefits Specialist will be at the Computer Lab locations to assist with the enrollment process. *(See page 6 for the open lab schedule)*	To make core benefit elections through ESS, please visit: columbus.munisselfservice.com Click on the Benefits Tab on the left side of the page to make your elections. *(Voluntary Benefits enrollments/changes/terminations are not available via ESS)*

Regardless of the method chosen to enroll, you are ultimately responsible for ensuring that the enrollment is correct and submitted by October 26, 2018.

What's New in Benefits for 2019

- **Short Term Disability** has been transferred from Trustmark to Voya. No action needs to be taken; each person who was enrolled in the Trustmark plan will automatically be transferred to Voya. If you would like to terminate coverage with Voya, you can do so during Open Enrollment 2019.
- You will not be able to continue Short Term Disability coverage with Trustmark and will receive detailed communication regarding this transition.
- **The Trustmark Universal Life Insurance** policy will no longer be available through payroll deductions. Your last Universal Life Insurance deduction will be on the December 28, 2018 paycheck. If you choose to continue your policy, Trustmark will provide you with options available to continue coverage.
- Columbus City Schools will be conducting a **Dependent Verification Audit** at the beginning of 2019. All employees with dependents who are enrolled in our benefit plans will be required to provide proof that they are an eligible dependent. Please start gathering dependent documents now in preparation for the audit.

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 employees	**Temporary employees**
Part-time employees working at least 20 hours per week	**Part-time employees working less than 20 hours per week**
Latchkey teachers	**Summer school employees**
Tutors scheduled for a minimum of 15 hours per week	**Part time hourly teachers (ie. LLI, Read 180, Home Instruction)**
ACA eligible employees (not normally benefits eligible but, worked an average of 30 hours per week over the course of the year)	**Substitutes (except for long term substitute teachers)**

Dependent 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. • Page 1 and signature page of employee's most recent Federal Income Tax Return (1040, 1040A or 1040EZ) listing the spouse; **OR** • Page 1 and certificate of Electronic Filing of employee's most recent Federal Income Tax Return (1040, 1040A
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 due to the dependent being incapable of self-sustaining employment by reason of a physically or mentally disabling injury, illness, or condition.	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.

***Benefit Specialists 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 26, 2018 to ensure coverage for your dependents beginning January 1, 2019.**

You will have 3 options to provide your dependent verification documents to the Benefits Department prior to the October 26, 2018 deadline:

- **Option 1** - **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.
- **Option 2** - Bring the documentation verifying dependent eligibility with you to complete your dependent enrollment to an Open Lab session at Kingswood Data Center, Central Enrollment, or the CEC Assembly Room. A member of the CCS Benefits Team will be on-site to collect your documents.
- **Option 3** - If you are unable to attend an open lab or email your documents, feel free to visit the benefits team at 270 East State Street 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.***

Open Lab – Schedule				
Day	Date	Time	Location	Address
Tuesday	10/16/2018	3:00pm-6:00pm	Kingswood Data Center	1091 King Avenue Columbus, Ohio 43212
Thursday	10/18/2018	3:00pm-6:00pm	CEC Assembly Room	270 East State Street Columbus, Ohio 43215
Tuesday	10/23/2018	3:00pm-6:00pm	Kingswood Data Center	1091 King Avenue Columbus, Ohio 43212
Wednesday	10/24/2018	8:00am-5:00pm	Central Enrollment (Records Day)	430 Cleveland Avenue Columbus, Ohio 43215
Monday	10/26/2018	3:00pm-6:00pm	CEC Assembly Room	270 East State Street Columbus, Ohio 43215

Verify that dependents are on your benefit 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.

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

How to Enroll, Change or Waive Coverage

Existing Employees

During Open Enrollment (October 9th - 26th, 2018), you **MUST** enroll or waive coverage; coverage begins January 1, 2019. For 2019, you may enroll through ESS or speak with a Benefits Specialist. (See **page 4** for additional information)

If you elect to waive benefits coverage, you will need to decline benefit coverage in ESS.

New Hires Between January 1 and October 1, 2018

You must enroll twice – If you have enrolled in benefits for the remainder of 2018, you will need to reconfirm your elections for 2019 through ESS.

New Hires After October 1, 2018

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 your elections in ESS. You may also enroll in Voluntary Benefits during your first 30 days of employment by visiting https://ccs.mybenefitsinfo.com or calling USEBSG at 1-800-735-0080 to schedule a Voluntary Benefit enrollment session. No action is required for Open Enrollment. Your core and voluntary benefits will roll over automatically.

When Coverage Begins

- If you are a current employee and enroll during the annual Open Enrollment period, your new coverage selections will be effective on January 1, 2019.
- If you are a new hire, have transferred into a benefits-eligible position, or returned from an unpaid leave of absence and let your benefits coverage lapse, you will need to make your elections within 30 days of your date of hire, transfer, or return to work date.
- Benefits will be effective on the first day of the month following 30 days of employment.
- For other changes like qualifying events, benefits are effective on the date of the event. For more information about qualifying events, refer to the qualifying event table on this page.

Terminating Voluntary Benefits

- To terminate voluntary benefits, please call 1-800-735-0080.

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 company letterhead)
Dependent child gains coverage from an employer	Letter of creditable coverage from an employer

When Coverage Ends

	CEA/ CAA Members	OAPSE/ CSCSA Members
Terminations/ Resignations	Benefits will end on the last day of the month of your last paycheck date.	Benefits will end on the last day of the month of your last paid work date.
Retirements	Core benefits will terminate on the last day of the month indicated on the Payroll and Deduction Schedule corresponding to the last date of paid benefit contributions.	
Overage Dependents	• Medical and Vision - Benefits end at the end of the month of your dependent's 26th birthday • Dental - Benefits end on your dependent's 23rd birthday	
Voluntary Benefits	Call USEBSG at 1-800-735-0080 to terminate voluntary benefits.	

Using ESS to Enroll in Benefits

How to Access ESS
http://columbus.munisselfservice.com

- **Log in:** using your 6-digit employee number and password You can find this number on your ID badge or pay statement. **If you have difficulty logging in, contact the CCS Help Desk at 614-365-8425 between the hours of 6:30am and 5:30pm.**
  - *Click* on the **ESS** link
  - *Click* on the **Benefits** tab on the left side of the screen (this tab shows you your current elections for 2018)
  - *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 2018 benefits which are listed in the Current Election column. When you make your elections for 2019, 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 in 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 2019 benefit choices.**

Leaves of Absence

FMLA (Family and Medical Leave Act of 1993)
If you need to take a leave of absence, the Human Resources Department will determine whether you are 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. You will pay for insurance under the same conditions (during those 12 weeks), as if you continued active employment. Once FMLA has been exhausted, you are responsible for the total cost to maintain benefits coverage. Once approved for FMLA leave, you will receive detailed documentation of your benefits continuation eligibility if you move into an unpaid status while on leave.

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. The Benefits Department will mail a written notice to you specifically outlining required payments to continue coverage for you and/or dependent(s). While on a leave, payments for your benefit contributions will be paid directly to the CCS benefits team. **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, please call the benefits team within the first 30 days from your return to work date to reinstate your benefits.**

To continue Voluntary Benefits while on leave, the you must contact USEBSG 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, if you choose to continue benefits, you must self-pay for the benefits:

- Classified employees will pay their normal benefit premium, not to exceed 2 years
- Certificated employees are responsible for 100% of the cost of the benefit premium

Voluntary Unpaid Leave
If you are approved by the Board of Education for an unpaid leave of absence, it is your responsibility to pay 100% (both Employer and Employee shares) of the cost should you choose to maintain benefit coverage, which can continue for up to two years. **If you choose to waive coverage while on unpaid leave, you will have 30 days from your return to work date to reinstate benefits by completing your elections online through ESS.**

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 Program (EAP).

Medical Benefits - Medical Mutual of Ohio

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

- 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 Select Basic and Select Plans are in-network only plans and do not provide benefits for out-of-network providers. The Choice Plans cover both in-network and non-network providers. The plans also differ in how much you pay out of your own pocket and the bi-weekly contributions.

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.

My Health Plan - Your Personalized Web Portal

All you need to register is your Medical ID card!

Visit the Medical Mutual website (member.medmutual.com) and click on *Register for an Account* on the right side of the page. Using information from your ID card, complete the form fields.

Time, Money and Total Health-Saving Features

- Order new ID cards
- Online customer service
- 24/7 access to your benefit book
- **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.

*For details, see the medical/prescription summaries included in this guide on pages 13 and 14

- **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.

- **Find a Provider** – The Find a Provider 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.

- **My Care Compare** – The Treatment Cost Estimator helps you make cost-effective choices by calculating approximate costs for certain procedures with in-network providers.

Disease Management Program
If you live with a chronic condition, having a coach to offer guidance and empowerment can be very helpful. Our Disease Management Program provides you with valuable information and a plan designed to meet your specific needs. The following conditions are eligible for the program:

- Asthma
- Chronic Obstructive Pulmonary Disease
- Coronary Artery Disease
- Diabetes
- Heart Failure

Maternity Management Program
If a new baby is on the way, our Maternity Program can offer education and support. The program includes access to a specially trained maternity health coach who can provide valuable knowledge, advice and comfort during the pregnancy.

Both the Disease Management Program and the Maternity Program are available at no additional cost. To check eligibility or to enroll, call (800) 861-4826. Select option 1 for Maternity or option 2 for Disease Management. You can also visit MedMutual.com/DiseaseManagement for more information.

Is My Doctor In The Network?

If You Are Not A Member:

- Go to providersearch.medmutual.com
- Select Group Plan
- Select SuperMed PPO
- Enter your Provider Type and Zip Code
- 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

Preventive Care Services

Prevent and Detect Disease Early

Staying healthy and living a long life starts with preventive healthcare. Preventive care can help you avoid illness and detect problems before you notice any symptoms – helping you stay healthy. Your medical benefit includes preventive heath services at no cost to you, as long as you are in-network.

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

Physician Office Services:

Annual Preventive Care Examinations	Immunizations
Well Baby and Child Care	Well Woman/ Well Man Examinations

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

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

Wellness Programs

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

- **Weight Watchers®** – call (800) 251-2583 for more information
- **GlobalFit** – Fitness club discounts
- **QuitLine** smoking-cessation program.
- **24 Hour Nurse Line** – Just call (888) 912-0636 to speak to an registered nurse for answers to your health questions.
- **Discounts** – Receive discounts on a variety of items including baby products, spas, hearing aids, drugstore items and health products.
- **CCS Wellness Initiative** – Healthy Bodies, Active Minds. For more information visit: www.ccsoh.us/wellness for more information.

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

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

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

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 Adults for the following conditions:

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 a virtual 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.

Your Prescription Drug Benefits

Pharmacy benefits are offered through Express Scripts. If you're enrolled in the Medical Plan, you are automatically enrolled in the Pharmacy benefit. If you choose not to enroll in Medical, you cannot enroll in Pharmacy. Your pharmacy information can be found on the front of your Medical Mutual ID Card. Coverage detail for the pharmacy benefit can be found on page 13 and 14.

Need Help? Call the Help Desk to resolve ESS password or log in issues at 614-365-8425

Guide on Where To Go For Care

	Why Go Here?	What Type Of Care Do They Provide?	What Are The Costs and Time Consideration?
Nurse Line	A free call-in service providing 24/7 access to registered nurses for answers to health related questions. To use this 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	A 24/7 online video service providing access to a board-certified physician. Using mobile phone, tablet, or computer. Wait times to speak to a doctor are typically less than 10 min.	• Asthma • Allergies • Bronchitis • Cold and Flu Symptoms • Earaches • Sinus Infections • Sprain or Strain • Urinary Tract Infection	• Requires a co-pay (office visit co-pay) • No appointment needed • Available 24/7 • Face-to-face visit using webcam
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	• Requires a co-pay (office visit co-pay) and/ or co-insurance • 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, deductible, 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 13 and 14

Certificated Employees & Administrators

	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)	$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		

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

	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)	$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			

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

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 must 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'd 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.

To locate a participating provider, call Delta Dental at1-800-282-0747, or visit the website at www.DeltaDentalOH.com.

	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)

The vision care benefit is available to you and your family at no cost to you; the employer pays the full cost for you and your enrolled dependents.

Note: 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 you pay less out of pocket when you see a participating VSP provider.

The network has expanded to include coverage at large retailers like Walmart and Pearl Vision. 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 allowance
Lenses (every 24 months)		
Single vision	Covered in full after $10 copay (see above)	$25 allowance
Lined Bifocal	Covered in full after $10 copay (see above)	$40 allowance
Lined Trifocal	Covered in full after $10 copay (see above)	$55 allowance
Contact lenses (every 24 months instead of eyeglass lenses and frames)		
Cosmetic	$105 allowance	$105 allowance
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 Dental Plan

You will not receive a card for your Dental benefit. Make an appointment and tell the doctor's office that you're a Delta Dental member and an employee of Columbus City Schools. Provide them with your name and social security number and your doctor's office will use this information to identify your account and obtain benefits authorization.

Your Vision Plan

You will not receive a card for your Vision benefit. Make an appointment and tell the doctor's office that you're a VSP member and an employee of Columbus City Schools. Provide them with your name and social security number and your doctor's office will use this information to identify your account and obtain benefits authorization.

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. Columbus City Schools 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 Group Term to Age 100 (page 28).

Why is having enough Life Insurance protection important?

If you have a spouse and/or children, they may rely on you to help keep the household running. 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
- Burial expenses

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

Your 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 certificated employees and administrators will receive $50,000 in Basic Life Coverage
- Part-Time certificated employees, who are benefits eligible, will receive $25,000 in Basic Life coverage
- Full-time classified employees receive $50,000 in Basic Life coverage
- Part-time classified employees, who are benefits eligible, will receive $25,000 in Basic Life coverage
- Eligible tutors will receive $20,000 in Basic Life coverage

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

Supplemental Life Insurance

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

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

- Will Preparation Services
- MetLife Estate Resolution Services
- Portability - if you retire or leave the company, take the insurance with you
- Grief Counseling

These services are included, at no cost to supplemental life insurance plan participants.

Need Help? Call the Help Desk to resolve ESS password or log in issues at 614-365-8425

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 (FSA) to help save income taxes on predictable eligible health and/or dependent care expenses.

There are two types of FSA plans that are available to you:

- **Health Care FSA** - Use these funds to pay for healthcare expenses like co-payments, prescriptions, glasses, etc.
- **Dependent Care FSA** - Use these funds to pay for childcare like preschool, daycare, adult daycare, summer day camp, and before and after school programs.

Health Care FSA:

- Estimate how much you expect to spend on eligible health care expenses for the plan year (January 1, 2019 through December 31, 2019). The minimum contribution is $260 per plan year and the maximum contribution you may elect is $2,500 per plan year.

- Throughout 2019, 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 VISA 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 or with the Discovery Benefits App available on iTunes or Google Play. *(See page 19 for more details)*

For a full list of qualifying FSA expenses, visit discoverybenefits.com/employees/eligible-expenses.

Dependent Care FSA:

- 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.

  Please visit FSAStore.com and take advantage of our partnership with the FSA Store and to easily shop for eligible expenses.

You must re-enroll in FSAs every year -your enrollment will not be carried over. You can make 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)

	21 Pay Health FSA	26 Pay (stretch) Health FSA	21 Pay Dependent FSA	26 Pay (stretch) Dependent FSA
Minimum	**$260 per year** $12.38 per pay	**$260 per year** $10.00 per pay	**$260 per year** $12.38 per pay	**$260 per year** $10.00 per pay
Maximum	**$2,500 per year** $119.05 per pay	**$2,500 per year** $96.15 per pay	**$5,000 per year** $238.10 per pay	**$5,000 per year** $192.31 per pay

Managing your Health and Dependent Care FSA Accounts

You can access your account either online or with the Benefits Mobile App. Access your benefits 24/7 to:

- Check your account balance and view account activity
- Get instant notifications on the status of your claims
- File a claim and upload documentation using your phone's camera
- Scan an item's bar code with your phone's camera to determine if it's an eligible expense
- Report a card lost or stolen
- Reset login credentials

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, you have up until March 15, 2019 to continue to incur medical expenses and use funds that they have not exhausted from your 2018 accounts.
  - For example, you can go to the dentist in February 2019, get a root canal and use money set aside between January 1 and December 31, 2018 to pay for this expense with a date of service in February 2019. ***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 2018. All submissions for reimbursement for the 2018 Dependent and Health Care Flexible Spending Accounts are due to Discovery Benefits no later than **April 30, 2019. 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 FSA, 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 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.

Employee Assistance Program (EAP) - Guidance Resources

Guidance Resources provides confidential, professional assistance and resources to you and members of your family free of charge. The program offers someone to talk to and resources to consult whenever and wherever you need them, 24 hours a day, seven days a week. The EAP covers up to four (4) visits per issue per member.

To arrange a **confidential** appointment with a specialist near you, call Guidance Resources at 1-800-774-6420. Appointments can be scheduled at any time. You can consult with a specialist in a face-to-face meeting or, if you prefer, a telephone appointment can be scheduled as well. Sessions are normally 50 minutes in length.

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

Guidance Resources Online and the GuidanceResources® Now app provides you with access to a broad variety of employee assistance services, such as getting resources and finding providers online and via your smartphone. Log on today to connect directly with a Guidance Consultant about your issue or to consult articles, podcasts, videos and other helpful tools.

Guidance Resources

Call: 1-800-774-6420

Online: www.guidanceresources.com

Web ID: CCS

Columbus City Schools Wellness Initiative:

Healthy Bodies, Active Minds

The CCS Wellness Initiative aims to support employee wellness through the development of comprehensive programming that addresses the eight dimensions of wellness: emotional, physical, social, occupational, financial, environmental, spiritual and intellectual.

As an employer, employee wellness improves personal wellbeing, may reduce absenteeism, benefit costs, and supports the district mission to educate students. The Wellness Initiative supports this mission: by improving student success by creating and fostering a culture of wellness that results in healthy behaviors among students and employees. The Board of Education supports the important work of this initiative, and the implementation is overseen by the Joint Insurance Committee.

Employees are encouraged to take advantage of the free benefits offered through the Wellness Initiative. Beyond investing in personal wellness, working toward healthier employees also benefits CCS as an employer as it reduces healthcare cost, saving our plan and employees money. The Wellness Initiative's robust offerings include but are not limited to:

- Biometric Screenings
- Flu Shot Clinics
- Onsite Fitness Classes
- Free/Reduced Fitness Discounts
- Wellness Professional Development Opportunities
- Special Wellness Programming

A comprehensive list of offerings can be found here, www.ccsoh.us/wellness.

Wellness is defined as optimal physical, social, and mental health to achieve a higher level of energy and vitality.

Vision Statement:

Because we know that the social, emotional and physical wellness of students and staff is vital to student success, the CCS organizational culture will support wellness, and our district will serve as a national school district model for health and wellness.

COLUMBUS CITY SCHOOLS

Classified Employees

2019 Employee Benefit Contributions Per Pay

Medical

21 Pay Plan	Select Basic	Select	Choice
Employee only	11.85	23.18	53.19
Employee plus Child	23.61	46.21	106.06
Employee plus Spouse (grandfathered rates)**	23.61	46.21	106.06
Employee plus Spouse*	235.74	258.34	318.19
Employee plus Children	34.86	68.19	156.49
Family (Employee plus Spouse and child(ren)) (grandfathered rates)**	34.86	68.19	156.49
Family (Employee plus Spouse and child(ren))*	347.83	381.17	469.47

26 Pay Plan	Select Basic	Select	Choice
Employee only	9.57	18.72	42.96
Employee plus Child	19.07	37.32	85.67
Employee plus Spouse (grandfathered rates)**	19.07	37.32	85.67
Employee plus Spouse*	190.41	208.66	257.00
Employee plus Children	28.15	55.08	126.40
Family (Employee plus Spouse and child(ren)) (grandfathered rates)**	28.15	55.08	126.40
Family (Employee plus Spouse and child(ren))*	280.94	307.86	379.19

* 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	3.98	3.22
Family	3.98	3.22

Life Insurance

	21 Pay Plan	26 Pay Plan
Basic Life $50,000 (Complementary Coverage)	0.00	0.00
Supplemental Life $50,000	2.94	2.38

Vision Care is fully paid for by Columbus City Schools

COLUMBUS CITY SCHOOLS

Certificated Employees & Administrators

2019 Employee Benefit Contributions Per Pay

Medical

21 Pay Plan	Select	Choice
Employee only	49.11	57.46
Employee plus Child	97.93	114.56
Employee plus Spouse (grandfathered rates)**	97.93	114.56
Employee plus Spouse*	274.17	290.80
Employee plus Children	144.50	169.05
Family (Employee plus Spouse and child(ren)) (grandfathered rates)**	144.50	169.05
Family (Employee plus Spouse and child(ren))*	404.51	429.06

26 Pay Plan	Select	Choice
Employee only	39.66	46.41
Employee plus Child	79.10	92.53
Employee plus Spouse (grandfathered rates)**	79.10	92.53
Employee plus Spouse*	221.45	234.88
Employee plus Children	116.71	136.54
Family (Employee plus Spouse and child(ren)) (grandfathered rates)**	116.71	136.54
Family (Employee plus Spouse and child(ren))*	326.72	346.55

* 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	3.98	3.22
Family	3.98	3.22

Life Insurance

	21 Pay Plan	26 Pay Plan
Basic Life $50,000 (Complementary Coverage)	0.00	0.00
Supplemental Life $50,000	2.94	2.38

Vision Care is fully paid for by Columbus City

COLUMBUS CITY SCHOOLS

Eligible Tutors

2019 Employee Benefit Contributions Per Pay

Medical

21 Pay Plan	Select	Choice
Tutors (15-25 scheduled hours)		
Employee only	225.88	234.23
Employee plus one (Child or Spouse)	450.41	467.04
Family (Employee plus Spouse and child(ren))	664.53	689.07
Tutors (Over 25 scheduled hours)		
Employee only	128.66	137.01
Employee plus one (Child or Spouse)	256.54	273.17
Family (Employee plus Spouse and child(ren))	378.50	403.05

26 Pay Plan	Select	Choice
Tutors (15-25 scheduled hours)		
Employee only	182.44	189.18
Employee plus one (Child or Spouse)	363.79	377.22
Family (Employee plus Spouse and child(ren))	536.73	556.56
Tutors (Over 25 scheduled hours)		
Employee only	103.92	110.66
Employee plus one (Child or Spouse)	207.21	220.64
Family (Employee plus Spouse and child(ren))	305.71	325.54

Dental

	21 Pay Plan	26 Pay Plan
Employee Only (15-25 hours)	19.90	16.08
Family (15-25 hours)	19.90	16.08
Employee Only (over 25 hours)	11.14	9.00
Family (over 25 hours)	11.14	9.00

Vision Care is fully paid for by Columbus City Schools

Tutors are not eligible for Supplemental Life Insurance

COLUMBUS CITY SCHOOLS

Latchkey Teachers

2019 Employee Benefit Contributions Per Pay

Medical

21 Pay Plan	Select	Choice
Employee only	128.66	137.01
Employee plus one (Child or Spouse)	256.54	273.17
Family (Child or Spouse)	378.50	403.05

26 Pay Plan	Select	Choice
Employee only	103.92	110.66
Employee plus one (Child or Spouse)	207.21	220.64
Family (Child or Spouse)	305.71	325.54

Dental

	21 Pay Plan	26 Pay Plan
Employee only	11.14	9.00
Family	11.14	9.00

Vision

	21 Pay Plan	26 Pay Plan
21 Pay Plan	1.24	1.00
26 Pay Plan	1.24	1.00

Latchkey Teachers are not eligible for Basic or Supplemental Life Insurance

Job Share Teachers

2019 Employee Benefit Contributions Per Pay

Medical

21 Pay Plan	Select	Choice
Job Share Percentage	50%	50%
Employee only	247.97	256.31
Employee plus Child	494.45	511.08
Employee plus Spouse (grandfathered rates)**	494.45	511.08
Employee plus Spouse*	582.57	599.20
Employee plus Children	729.53	754.08
Family (Employee plus Spouse and child(ren)) (grandfathered rates)**	729.53	754.08
Family (Employee plus Spouse and child(ren)) *	859.54	884.09

26 Pay Plan	Select	Choice
Job Share Percentage	50%	50%
Employee only	200.28	207.02
Employee plus Child	399.36	412.80
Employee plus Spouse (grandfathered rates)**	399.36	412.80
Employee plus Spouse*	470.54	483.97
Employee plus Children	589.24	609.06
Family (Employee plus Spouse and child(ren)) (grandfathered rates)**	589.24	609.06
Family (Employee plus Spouse and child(ren))*	694.24	714.07

*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, 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	21.89		**21 Pay -** Employee only	2.22
21 Pay - Family Coverage	21.89		**21 Pay -** Family Coverage	2.22
26 Pay - Employee only	17.68		**26 Pay -** Employee only	1.79
26 Pay - Family Coverage	17.68		**26 Pay -** Family Coverage	1.79

Supplemental Life Insurance ($25,000)

21 Pay Plan	2.94
26 Pay Plan	2.38

Voluntary Benefit Choices

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 visit https://ccs.mybenefitsinfo.com to schedule a co-browsing session with a Benefits Specialist. See Page 4 for instructions.

- New employees will need to call USEBSG at 800-735-0080 within 30 days of employment to schedule a Voluntary Benefits enrollment session.

Short Term Disability Insurance - Voya

For many households, going without income for even a few weeks can be devastating. Short Term Disability Income Insurance can help protect your finances if you experience an eligible illness or injury that leaves you unable to work. It provides benefits to replace up to 60% of your weekly earnings for 26 weeks. These weekly benefits allow you to concentrate on getting better and when possible, back to work.

How the Plan Works

Weekly benefits begin after 14 days of disability from an illness or injury. You may choose a weekly benefit amount of, up to, $1,400 (but not more than 60% of your income)

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.

Filing a Claim

To File a Short Term Disability Claim or to talk to a customer service representative, call 1-888-305-0602.

Accident Insurance - Voya

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, 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 as you see fit
- 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

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
- Accident Care
- Dislocations
- Fractures
- Common Injuries
- Accidental Death & Dismemberment
- Catastrophic Accident Benefits
- 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

**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 Insurance - Voya

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. Critical Illness Insurance is a limited benefit policy, 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

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 your 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?

- The Wellness Benefit 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 tests, serum cholesterol tests for HDL & LDL levels, mammography, colonoscopy and stress tests on a 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 Life Insurance - Allstate

Life is unpredictable. You don't know when or how death may occur 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. Your rate is guaranteed for the first five years of coverage and 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 - LegalEASE (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:

- Debt 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.

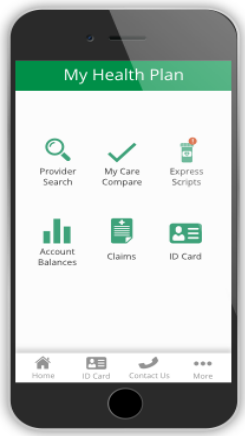
To learn more about Pet Insurance please visit their web site at www.petinsurance.com. Benefits Specialists will not be able to enroll employees for Pet Insurance.

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/employeebenefits.

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

Go Mobile

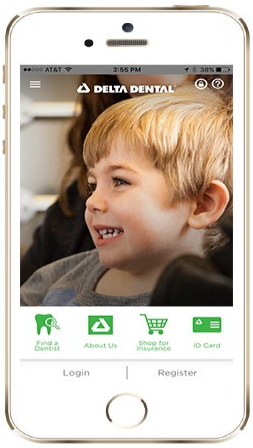


Medical Mutual of Ohio

Manage your health plan information - anytime, anywhere.

You can:

- View your claims
- Access your ID card
- Check your deductible and out-of-pocket spending
- Find a provider

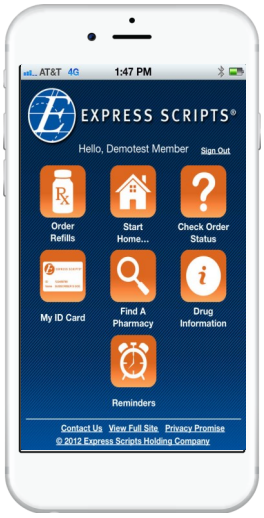


Delta Dental of Ohio

The Delta Dental mobile app makes it easy for you to get the most of their dental benefits anytime, anywhere.

You can:

- Find a dentist
- Use a tooth brushing timer
- Check claims
- View coverage
- Display ID card

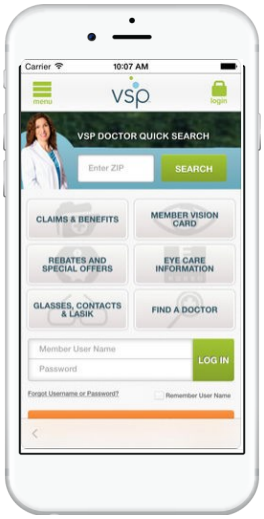


Express Scripts

With the Express Scripts mobile app, managing your medication is a snap!

You can:

- View orders
- Check drug interactions
- Find the closest retail pharmacy
- Transfer a prescription to Home Delivery
- Get personalized alerts to help make sure you're following your doctor's prescribed treatment plan

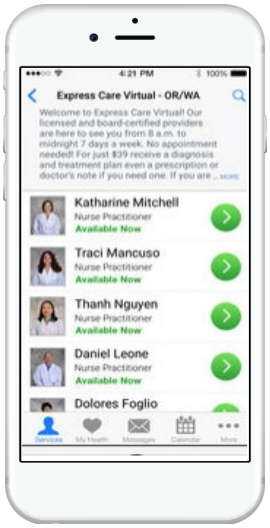


Vision Service Plan

Manage your eye care needs at any time, and from anywhere, with VSP Vision Care On The Go.

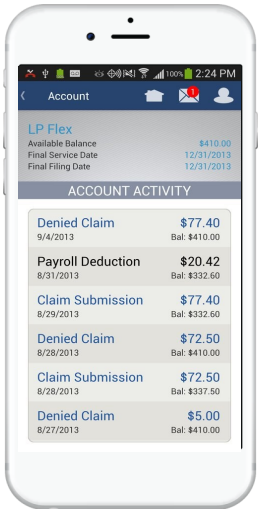
You can:

- Find a doctor
- Check your coverage
- Access your vision card
- Shop the latest eyewear fashions 24/7



Virtual Doctor's Visit Cleveland Clinic Express Care

Express Care Virtual provides a convenient alternative to a traditional doctor's office or urgent care visit. Visit with a licensed, board-certified health care provider by video using your smartphone or tablet. Get a diagnosis and treatment and doctor's note as needed. There's no waiting and no hassle. Just excellent care.



Discovery Benefits

Save time and hassles while making the most of your FSA health benefit accounts by quickly checking your balances and details and substantiating claims by taking a picture of your receipt, through the app, and submitting it electronically. The secure app makes managing your health benefits easy through real-time access and intuitive navigation to all your important account information on the go!

Important Notices

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/sheand/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.

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.

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).

Special Enrollment Notice

If you are declining enrollment for yourself or your 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 you 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, Manager of Employee Benefits

Address: 270 East State Street, 43215

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

Important Notice from Columbus City Schools about Your Prescription Drug Coverage and Medicare for Plan Year 2019

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.

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.

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 614-365-6475 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).

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, 2018. Contact your State for more information on eligibility –

ALABAMA – Medicaid	**FLORIDA – Medicaid**
Website: http://myalhipp.com/ Phone: 1-855-692-5447	Website: http://flmedicaidtplrecovery.com/hipp/ Phone: 1-877-357-3268
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.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: http://www.indianamedicaid.com Phone 1-800-403-0864
COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	**IOWA – Medicaid**
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+: Colorado.gov/HCPF/Child-Health-Plan-Plus CHP+ Customer Service: 1-800-359-1991/ State Relay 711	Website: http://dhs.iowa.gov/hawk-i Phone: 1-800-257-8563

KANSAS – Medicaid	NEW HAMPSHIRE – Medicaid
Website: http://www.kdheks.gov/hcf/ Phone: 1-785-296-3512	Website: https://www.dhhs.nh.gov/ombp/nhhpp/ Phone: 603-271-5218 Hotline: NH Medicaid Service Center at 1-888-901-4999
KENTUCKY – Medicaid	**NEW JERSEY – Medicaid and CHIP**
Website: https://chfs.ky.gov 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 CHIP Phone: 1-800-701-0710
LOUISIANA – Medicaid	**NEW YORK – Medicaid**
Website: http://dhh.louisiana.gov/index.cfm/subhome/1/n/331 Phone: 1-888-695-2447	Website: https://www.health.ny.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 TTY: Maine relay 711	Website: https://dma.ncdhhs.gov/ Phone: 919-855-4100
MASSACHUSETTS – Medicaid and CHIP	**NORTH DAKOTA – Medicaid**
Website: http://www.mass.gov/eohhs/gov/departments/masshealth/ Phone: 1-800-862-4840	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825
MINNESOTA – Medicaid	**OKLAHOMA – Medicaid and CHIP**
Website: https://mn.gov/dhs/people-we-serve/seniors/health-care/health-care-programs/programs-and-services/other-insurance.jsp 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 Phone: 1-800-699-9075
MONTANA – Medicaid	**PENNSYLVANIA – Medicaid**
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084	Website: http://www.dhs.pa.gov/provider/medicalassistance/healthinsurancepremiumpaymenthippprogram/index.htm Phone: 1-800-692-7462
NEBRASKA – Medicaid	**RHODE ISLAND – Medicaid**
Website: http://www.ACCESSNebraska.ne.gov Phone: (855) 632-7633 Lincoln: (402) 473-7000 Omaha: (402) 595-1178	Website: http://www.eohhs.ri.gov/ Phone: 855-697-4347
NEVADA – Medicaid	**SOUTH CAROLINA – Medicaid**
Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	Website: https://www.scdhhs.gov Phone: 1-888-549-0820
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://mywvhipp.com/ Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
UTAH – Medicaid and CHIP	**WISCONSIN – Medicaid and CHIP**
Medicaid Website: https://medicaid.utah.gov/ CHIP Website: 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/ Phone: 1-800-250-8427	Website: https://wyequalitycare.acs-inc.com/ Phone: 307-777-7531
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, 2018, 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/agencies/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.

HIPPA Privacy Notice

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. **Please review it carefully.**

Your Rights

You have the right to:

- Get a copy of your health and claims records
- Correct your health and claims records
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

Your Choices

You have some choices in the way that we use and share information as we:

- Answer coverage questions from your family and friends
- Provide disaster relief
- Market our services and sell your information

Our Uses and Disclosures

We may use and share your information as we:

- Help manage the health care treatment you receive
- Run our organization
- Pay for your health services
- Administer your health plan
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests and work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get a copy of health and claims records

- You can ask to see or get a copy of your health and claims records and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health and claims records, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct health and claims records

- You can ask us to correct your health and claims records if you think they are incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will consider all reasonable requests, and must say "yes" if you tell us you would be in danger if we do not.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations.
- We are not required to agree to your request, and we may say "no" if it would affect your care.

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice
You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you
If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
We will make sure the person has this authority and can act for you before we take any action.
File a complaint if you feel your rights are violated
You can complain if you feel we have violated your rights by contacting us using the information on page 1.
You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.**
We will not retaliate against you for filing a complaint.

Your Choices
For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.
In these cases, you have both the right and choice to tell us to:
- Share information with your family, close friends, or others involved in payment for your care
- Share information in a disaster relief situation

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we *never* share your information unless you give us written permission:
- Marketing purposes
- Sale of your information

Our Uses and Disclosures
How do we typically use or share your health information?
We typically use or share your health information in the following ways.
Help manage the health care treatment you receive
We can use your health information and share it with professionals who are treating you.
Example: A doctor sends us information about your diagnosis and treatment plan so we can arrange additional services.
Run our organization
We can use and disclose your information to run our organization and contact you when necessary.
We are not allowed to use genetic information to decide whether we will give you coverage and the price of that coverage. This does not apply to long term care plans.
Example: We use health information about you to develop better services for you.
Pay for your health services
We can use and disclose your health information as we pay for your health services.
Example: We share information about you with your dental plan to coordinate payment for your dental work.
Administer your plan
We may disclose your health information to your health plan sponsor for plan administration.
Example: Your company contracts with us to provide a health plan, and we provide your company with certain statistics to explain the premiums we charge.
How else can we use or share your health information?
We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html**.**
Help with public health and safety issues
We can share health information about you for certain situations such as:
- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Respond to lawsuits and legal actions
We can share health information about you in response to a court or administrative order, or in response to a subpoena.
Our Responsibilities
We are required by law to maintain the privacy and security of your protected health information.
We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
We must follow the duties and privacy practices described in this notice and give you a copy of it.
We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.
Comply with the law
We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.
Respond to organ and tissue donation requests and work with a medical examiner or funeral director
We can share health information about you with organ procurement organizations.
We can share health information with a coroner, medical examiner, or funeral director when an individual dies.
Address workers' compensation, law enforcement, and other government requests
We can use or share health information about you:
For workers' compensation claims
For law enforcement purposes or with a law enforcement official
With health oversight agencies for activities authorized by law
For special government functions such as military, national security, and presidential protective services
Respond to lawsuits and legal actions
We can share health information about you in response to a court or administrative order, or in response to a subpoena.
Our Responsibilities
We are required by law to maintain the privacy and security of your protected health information.
We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
We must follow the duties and privacy practices described in this notice and give you a copy of it.
We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see:
www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html**.**

Changes to the Terms of this Notice
We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, on our web site, and we will mail a copy to you.

09/18/2018
Courtney Hale, Manager of Employee Benefits
chale@columbus.k12.oh.us

COLUMBUS
CITY SCHOOLS