COLUMBUS STATE
COMMUNITY COLLEGE

Employee Benefits Packet

Presented by:

Columbus State Community College

550 E. Spring Street

Columbus, Ohio 43215

Human Resources Department

Telephone (614) 287-2408

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** These forms will need to be returned to HR after completion.

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Full Time Benefit Information Packet

Dear Full-Time Employee:

On behalf of Columbus State Community College and the Benefit Team, we are pleased to welcome you to your new position. There are many benefit options available to you as a full-time employee and we look forward to the opportunity to meet with you at your assigned New Hire Orientation Meeting.

This packet contains valuable information and resources to assist you with your benefit selections. Please review the packet and complete the benefit forms prior to your meeting. Most questions can be answered by visiting the Columbus State website at: http://www.cscc.edu/about/human-resources/.

We will be at the meeting to answer additional questions you may have after reviewing the packet and website. The meeting is designed to provide an overview of the benefits options, to answer your questions, and to review the required paperwork. Please bring the following documents with you to the meeting;

-the entire benefit packet;

-completed paperwork; and

-required dependent verification (if you are enrolling dependents on any of the plan options)

Sincerely,

Human Resources

Benefit Plan Contact Information:

Benefit Paperwork and Information is located at: www.CSCC.edu (About CSCC, Faculty & Staff, under HR – Employee Benefits, Benefits)
Please return all benefit paperwork to the CSCC **Human Resources Department – RH**

If you need to order ID cards, please visit the appropriate vendor website

HDHP/HSA/Alternate Plan: Contact UHC first to verify benefits and eligibility or to resolve claim questions. **UnitedHealthcare Plan # 708233** Phone: 866-314-0335 Website: www.myuhc.com	**PPO/CORE Plan:** Contact UHC first to verify benefits and eligibility or to resolve claim questions. **UnitedHealthcare Plan # 708233** Phone: 866-633-2446 Website: www.myuhc.com
HSA Contributions: **Jason Love** 614-287-5972	**Wellness Initiative – Health Rewards:** Wellness Coordinator: **Nichole Bowman-Glover** Phone: 614-287-3989
Enrollment/Eligibility Advocate: Changes or Modifications **Monessa Bradford** 614-287-2107	**Claims Advocate:** After you have exhausted avenues with the applicable vendor to resolve the issue, contact: **Monessa Bradford** 614-287-2107
COBRA: **UnitedHealthcare Benefit Services** **OptumHealth Financial Services** Phone: 1-866-747-0048	**Life Insurance Questions:** **MetLife** Waiver of Premium Customer Service: 1-800-300-4296 Life Conversions Customer Service: 1-877-275-6387 Life Claims Customer Service: 800-638-6420 prompt 2
Retirement – STRS, SERS, 457, and 403b : **FSA Contributions:** Program Coordinator of Retirement Benefits: **Twila Wiley** 614-287-2422 **TASC Id# 4901-4755-9523** 800-422-4661	
Vision Plan: **VSP Plan #30008366** Phone: 800-877-7195 www.Vsp.com	**Dental Plan:** **Delta Dental Plan #0007414** Phone: 800-524-0149 www.Deltadentaloh.com
EAP: **Matrix** Phone: 614-475-9500 or 800-886-1171 www.matrixpsych.com	
Fee Waiver **Susan Thompson** 614-287-2406	**Tuition Reimbursement** **Carmelita Boyer** 614-287-2407

COLUMBUS STATE COMMUNITY COLLEGE

Benefit Checklist

Coverage Type	Forms Included	
Pre or Post Tax		
Section 125 Cafeteria Plan Premium Reduction Option	☐ **Yes**	☐ **No**
Consolidated Form:		
Medical-UHC, Dental-Delta, Vision-VSP	☐ **Yes**	☐ **No**
If electing coverage for dependents Please include dependent verification	☐ **Yes**	☐ **No**
Domestic Partner Affidavit Included	☐ **Yes**	☐ **No**
Working SP/DP Premium Affidavit Included	☐ **Yes**	☐ **No**
If Electing the HDHP/HSA		
HSA banking form only if electing the HDHP/HSA	☐ **Yes**	☐ **No**
FSA		
FSA – Flexible Spending Account Health Care/Dependent Care	☐ **Yes**	☐ **No**
Life and AD&D Form		
Group Life/AD&D Insurance MetLife	☐ **Yes**	☐ **No**
Long Term Disability Insurance MetLife	☐ **Yes**	☐ **No**
Additional Life/AD&D MetLife	☐ **Yes**	☐ **No**
Additional Two Times Life Benefit		
Evidence of Insurability form	☐ **Yes**	☐ **No**

All required paperwork listed above is enclosed.

_____ _____

Employee Signature Date

This form must be returned to Human Resources with all required documents and documentation within 31 days from your date of hire.

I have been provided an opportunity to elect benefits but I have not turned in my paperwork. I certify that if I do not turn the paperwork into Human Resources by _____, I waive all coverage. I understand that I will not be eligible to elect coverage until the next Open Enrollment or through a Special Enrollment with a Qualified Life Event.

_____ _____

Employee Signature Date

Take Advantage of the Section 125 Cafeteria Plan Premium Reduction Option

The Premium Reduction Option allows you to pay your share of selected group and voluntary insurance premium(s) with before-tax dollars. As a result, you pay less FICA, less federal and less state taxes (because your income is reduced), and you take home more pay.

- To enroll, all you need to do is complete the election section below and return to Human Resources. The Payroll Department will automatically deduct your share of certain employer designated group/voluntary insurance premiums with before-tax dollars each pay period.

- Copies of the Plan documents are available for your inspection in Human Resources.

NOTE: You cannot deduct medical costs on your income taxes if you participate in the Section 125 Cafeteria Plan. For assistance in this area, please contact your personal accountant.

Election Form

☐ **Yes** I want to use pre-tax dollars to fund selected benefit contributions as designated under my employer's Section 125 Premium Reduction Option. This election will go into effect on the plan effective date, or if the plan effective date has already occurred, on the date I become eligible to participate.

While a participant, I understand that I may not increase or decrease the amount of my income reduction until the next plan year except to reflect a change in my family status (i.e., marriage, birth of a child, divorce, etc.)

Signature _____

Print Name _____

Date Signed _____

☐ **No** I do not wish to allow an income reduction under my employer's Section 125 Premium Reduction Option.

Signature _____

Print Name _____

Date Signed _____

Benefit Enrollment/Change/Cancellation Form for UHC, Delta, and VSP

Employer Section: Columbus State Community College			**Hire Date:**
	Group Number	**Group Plan**	
UHC	708223	☐ Core PPO Plan_____	☐ HDHP/HSA Plan
Delta	0007414	☐Dental	
VSP Plan	30008366	☐ Vision	
Health Effective/Change Date	Dental Effective/Change Date	Vision Effective/Change Date	

Employee Complete Sections 1 - 8

1. Reason for Change				
Choose Qualifying Event	Event date: / /			
☐ Newhire	☐ Annual open enrollment	☐ Rehire (date) / /	☐ COBRA	☐Special enrollment / Life event (complete section 2)

2. Special enrollment/Life event		**3. Type of Coverage / Plan**		
☐ Marriage	☐Status Change PT/FT	***Health Coverage - UHC***	***Dental Coverage - Delta***	***Vision Coverage - VSP***
☐Court Order	☐Partner/Spouse's open enrollment	☐Core Plan	☐Dental Plan -	☐ Vision
☐ Birth	☐ Other*include legal document	☐HDHP/HSA Plan		
		☐ Employee only	☐ Employee only	☐ Employee only
		☐ Family coverage	☐ Family coverage	☐ Family coverage
		☐ Waive/Decline (See # 7)	☐ Waive/Decline (See # 7)	☐ Waive/Decline (See # 7)

4. Employee Information						
Last name	First name, MI	Date of birth	Age	Sex ☐ M ☐ F	Social Security #	☐ Single ☐Married ☐Divorced ☐Widowed
Home Address		City	State	Zip code	County	
Home telephone		e-mail address			Other Coverage Indicator: ☐Yes ☐No	

5. Other Health Coverage. Please check one:

On the day this coverage begins, will you, your spouse/partner, or any of your dependents be covered under any other health plan or policy including Medicare?

☐ Yes (continue completing this sectionand check the other coverage indicator in section five) ☐ No (skip the rest of this section)

Provide name, phone number and address of the other coverage / insurance company	Policy / certificate number	Effective date / /

Policy / certificate holder's name	Policy holder's ID number	Date of birth / /	Relationship to applicant

If you and / or your dependents are enrolled in Other coverage including Medicare complete the following:

Enrollee's names (s)	Medicare / Medicaid ID#	Medicare Part A Effective date / /	Medicare part B Effective date / /	ESRD onset date / /
Enrollee's names (s)	Medicare / Medicaid ID#	Medicare Part A Effective date / /	Medicare part B Effective date / /	ESRD onset date / /

Reason for Medicare entitlement:
☐ Age ☐ Disability ☐ ESRD & Disability ☐End State Renal Disease (ESRD)

6. Family Information (Spouse/Partner and dependents to be added/changed/cancelled) SUPPORTING DOCUMENTATION MUST BE INCLUDED WITH THE ENROLLMENT FORM – TAX DOCUMENTATION/BIRTH CERTIFICATES

(1) ☐Add ☐ Cancel	Last name		First name, MI	
Date of Birth / /	Sex ☐ M ☐ F	Social Security #	Relationship to employee ☐ Spouse ☐Child ☐Partner ☐Step Child	Other Coverage Indicator: ☐ Yes ☐ No
If the dependent's address is different than the employee, please provide full address.				

(2) ☐Add ☐ Cancel	Last name		First name, MI	
Date of Birth / /	Sex ☐ M ☐ F	Social Security #	Relationship to employee ☐Other ☐Step Child ☐ Child ☐Partner's Child	Reason for change / Other Coverage Indicator: ☐Yes ☐No
If the dependent's address is different than the employee, please provide full address.				

(3) ☐Add ☐ Cancel	Last name		First name, MI	
Date of Birth / /	Sex ☐ M ☐ F	Social Security #	Relationship to employee ☐Other ☐Step Child ☐Child ☐Partner's Child	Reason for change / Other Coverage Indicator: ☐Yes ☐No
If the dependent's address is different than the employee, please provide full address.				

6. (con't). Family Information (Spouse and dependents to be added/changed/cancelled Attach a separate sheet if necessary)

(4) ☐Add ☐ Cancel		Last name		First name, MI	
Date of Birth / /	Sex ☐ M ☐ F	Social Security #	Relationship to employee ☐Other ☐Step Child ☐Child ☐Partner's child	Reason for change	Other Coverage Indicator: ☐Yes ☐No
If the dependent's address is different than the employee, please provide full address.					
(5) ☐Add ☐ Cancel		Last name		First name, MI	
Date of Birth / /	Sex ☐ M ☐ F	Social Security #	Relationship to employee ☐Other ☐Step Child ☐Child ☐Partner's child	Reason for change	Other Coverage Indicator: ☐Yes ☐No
If the dependent's address is different than the employee, please provide full address.					

7.Waive/Decline coverage for employee and / or any eligible dependent not enrolling (Please skip to section 8 if not waiving/declining any coverage type)

Check all that apply. Waive/Decline: ☐ Health ☐ Dental ☐ Vision ☐ All

I decline coverage for: ☐Myself ☐Spouse/Partner ☐Dependent Children ☐Myself and all dependents	I Decline coverage due to the existence of other coverage: ☐ Spouse/Partner Employer's Plan ☐VA Eligibility ☐ Individual Plan ☐ Medicare/Medicaid ☐No other coverage at this time
Name of Employer where the above is covered by insurance (if applicable) _____ _____ Carrier: ☐ Other carrier (give name, ID#)	I certify that I have been given an opportunity to apply for the employer's health benefits plan, and after careful consideration, have decided not to take advantage of this offer. In the event I wish to apply for such benefits hereafter, I may do so, subject to established procedures. I understand that by waiving coverage at this time, I will not be allowed to participate unless I experience a life change event, or at the next open enrollment.
Employee signature to waive/decline coverage:	Date:

8.Read these Significant Terms, Conditions and Authorizations carefully before signing. Please review your application for errors or omissions.

(a) I authorize deduction from my wages if necessary for the required payment for the benefit for which I, or any dependents have applied.	I acknowledge that I have read the Significant Terms, Conditions and Authorizations, and I accept such provisions as a condition of enrollment in the benefit plan. I represent that the answers given to all questions on this enrollment form are true and accurate to the best of my knowledge and I understand they are being relied on by UHC, Delta Dental, and/or VSP in accepting this application. Any person who knowingly and with intent to defraud any insurance company, health maintenance organization, self-insured plan, or other plan, or other person, files an application for insurance or other form of health care coverage containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime. I confirm that the information I have provided on this form is complete and accurate. I give this authorization for and on behalf of any eligible dependents and myself if covered by the Plan. I am acting as their agent and representative. By signing this form, I understand that knowingly providing false or misleading information in this form may result in any or all of the following actions by Columbus State Comminty College: 1) loss of coverage; 2) disciplinary action, up to and including removal; 3) collection action to recoup payments of benefits and claims paid for individuals determined to be ineligible dependents; and/or 4) civil and/or criminal prosecution.
(b) I am applying for the benefit selected on this application. If I select a coverage, or combination of coverages, not available to me and/ or a class for which I am not eligible, I agree that my selection(s) is hereby automatically amended to be consistent with the employer's application.	
(c) I am responsible to timely notify my employer of any change that would make me or any dependent ineligible for benefits.	
(d) I understand that the health benefit plan that I selected provides reimbursement for certain costs, which are more fully described in the current Certificate of Coverage. I understand there may be instances where treatment decisions made by my physician or me or medical expense which I have incurred may not be covered by my health plan.	
(e) I understand that information collected in connection with administration of the benefit plan may be used to bring to my attention health products or services that might be valuable to me and otherwise permitted by law. I understand that you may combine that information with other information so that it is no longer individually identifiable and use it for commercial and other purposes.	
(f) I attest that I have reviewed the Dependent Eligibility Definitions and that the information and documentation I am submitting are true and accurate.	
Employee signature to enroll in selected benefit plans:	**Date** / /

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REQUIRED DEPENDENT VERIFICATION INFORMATION

Dependents	Eligibility Definition	Required Documentation
SPOUSE/DOMESTIC PARTNER	A member of the opposite sex to whom you are legally married. A domestic partner is a member of the same or opposite sex that meets the criteria as outlined in the affidavit.	• A copy of the top half of the front page of the employee's most recently filed federal tax return that includes your spouse. ***You may black out all the financial information and ALL BUT the last 4 digits of your social security number; or*** • Photocopy of marriage certificate if marriage has occurred within one year of eligibility. • For the domestic partner, at least three of the documents described in the Affidavit.
CHILDREN Eligible dependent children include: Natural Children Step children Legally Adopted Children Children placed for adoption Children for whom legal guardianship has been awarded to employee or his/her spouse/partner	Medical only: Dependent children up to the age of 26 – According to the Health Reform Definition. Dental, Vision, and Life: Unmarried children residing in the U.S. who are under the age of 19, or 25 if there is evidence the children are: • Full time students at accredited schools, not regularly employed on a full time basis and who are primarily dependent upon the employee for support and maintenance; • Ordered to be covered by a Qualified Medical Child Support Order or other court or administrative order. Please see additional eligibility for Qualifying Disabled Children	• ***Natural Children:*** Photocopy of birth certificates showing employee's name. • ***Step Children:*** Photocopy of birth certificates showing employee's spouse's name **and** a copy of marriage certificate showing the employee and parent's name. • ***Adoptions/Legal Guardianships:*** Photocopy of Affidavits of Dependency, Final Court Order with presiding judge's signature and seal ***or*** Adoption Final Decree with presiding judge's signature or seal. • ***Children of the domestic partner***: Photocopy of birth certificates showing the partner's name. • If applicable: A copy of the top half of the front page of the employee's most recently filed federal tax return that includes your child/ren. ***You may black out all the financial information and ALL BUT the last 4 digits of your social security number.***

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MEDICAL PLAN WORKING SPOUSE/DOMESTIC PARTNER (SP/DP) PREMIUM AFFIDAVIT

A $50/$66.66 per pay (24/18 month pay schedule) charge will be added to your premium if you have elected coverage for your SP/DP and your SP/DP is eligible for coverage through his/her employer but elects not to enroll. If your SP/DP is eligible for coverage and is a full-time Columbus State employee, the premium is waived.

____I have not elected coverage for a SP/DP on The College's medical plan.

____I have my SP/DP enrolled in The College's medical plan, and my SP/DP does not have medical coverage available through his/her employer; or my SP/DP does not work.

____I have my SP/DP enrolled in The College's medical plan as secondary and my SP/DP is also enrolled in health coverage through his/her employer.

Spouse/Domestic Partner name: _____

Spouse Employer name: _____

Group #_____

Group Medical Plan name: _____

Cert. # _____

____I have my SP/DP enrolled in The College's medical plan and my SP/DP has medical coverage available through his/her employer and has elected not to enroll in their medical plan. (I understand the $50/$66.66 per pay premium will be applied & authorize a deduction from my pay check on a pre-tax basis.) If this form is not received by the Human Resource Department and your SP/DP is enrolled in coverage, you will be charged the surcharge until this form is received. If your SP/DP loses or obtains health coverage through their employer, you have 31 days to notify the Human Resource Department of such change. The Human Resource Department needs to be notified in writing of this and all Family Status changes within 31 days of when the change occurred. Failure to notify the Human Resource Department in a timely manner will restrict you from making a change until the next annual open enrollment period. My signature below indicates that the facts set forth on this form are true and complete to the best of my knowledge. I also understand that if my SP/DP group health insurance status changes, it is my responsibility to notify the Human Resource Department in writing within 31 days of such change. Any false statements written on this form or on future forms as it relates to SP/DP health information shall be considered grounds for disciplinary action.

_____ Name (Please Print)

_____ Name (Signature)

_____ Employee #

_____ Date

FlexSystem™

TASC™

Full Service Health Savings Account (HSA) Enrollment Kit

Enrollment

Group Number: 4700-9284-3657 Employer Name: Columbus State Community College

Social Security Number: ___-___-___ Enrollment- Check One: ☐ New ☐ Renewal

Employee Last Name: _____ First Name: _____ Middle Initial: _____

Employee Address: _____ City: _____ State: _____ Zip Code: _____

I authorize Total Administrative Services Corporation, hereinafter called TASC, to act on my behalf to transact the designated debit and credit entries in the Health Savings Account established in my name. I request the following amount(s) to be deducted pre-tax from my payroll:

	Annual Benefit Amount *		# of Payrolls		Per Payroll Amount
Employee HSA Contribution	$_____	divided by	_____	=	$ _____
Employer HSA Contribution	$_____	divided by	_____	=	$ _____

* See the HSA Participant Reference Guide for more information.

I hereby authorize TASC, to facilitate credit entries to the account indicated below and the financial institution named below, hereinafter called FINANCIAL INSTITUTION, to credit the same to such account. I acknowledge that the origination of ACH transactions to my account must comply with the provisions of U.S. law.

Personal Account (REQUIRED in order to access funds on www.tasconline.com for the Full Service HSA)

Financial Institution Name: _____ Branch: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Account Routing Number: _____ Account Number: _____

Account Type: (one must be checked) ☐ Checking ☐ Savings ☐ Other _____

Please Attach A Copy Of A Voided Check To The Enrollment Form.

Fill in the above information or use on-line activation:
Log-on to your personal account at www.tasconline.com following the set-up of your account and use the HSA Management link. Enter your personal bank routing and account information.

Authorization (Please read very carefully)

This authority is to remain in full force and effect until TASC has received written notification from me of its termination in such time and manner as to afford TASC and my FINANCIAL INSTITUTION a reasonable opportunity to act on it.

I certify the above information to be true to the best of my knowledge. I have read the information on the HSA Participant Reference Guide, and understand and agree to the terms and conditions stated within it. I agree to have my compensation reduced by the deduction amount(s) stated above. I further understand that the Health Savings Account deduction will be in effect until I cancel or terminate my participation, annual renewal of the HSA is unnecessary, and I may make changes at any time to my HSA contribution. Furthermore, I give TASC the authorization to obtain my Health Savings Account balance information for the sole purpose of Plan administration and customer service. I authorize my employer to payroll deduct my HSA contribution.

Signature _____ Date _____

Enrollment Form Instructions

Section 1 – Enrollment: Enter information requested in the space indicated. Refer to your employer for the correct Group Number and Company Name. Make sure to have this information available when calling for enrollment assistance.

Section 2 – Personal Account Information: Enter information regarding your personal banking account to be used for Transfer Requests in the space indicated. The Account Routing Number, the Type of Account, and the Account Number itself are required in order to set up your HSA. Be sure to print legibly when completing this section.

Section 3 – Authorization: After you have read the entire form, and the HSA Participant Reference Guide, sign the form and date it. **Return the completed and signed form to your employer.**

IMPORTANT: In addition to this form, you should have received and must complete three documents from our partner financial institution, M&I Bank FSB. These documents must be completed, signed, and returned to TASC as soon as possible. You will not be able to withdraw monies from your HSA Account until these documents are returned to TASC.

Frequently Asked Questions

1. What does a FlexSystem Health Savings Account (HSA) offer? A FlexSystem HSA allows you to make tax-free payroll contributions to the Account to pay for certain out-of-pocket medical expenses. Paying for certain benefits with tax-free dollars reduces the amount you pay in taxes and increases your take-home pay. Every dollar paid on a tax-free basis results in a savings to you. To be eligible you must participate in a High Deductible Health Plan (HDHP), which is a health plan with an annual deductible of not less than $1,100 for single coverage and $2,200 for family coverage.

2. How does it save money? Employee contributions made on a pre-tax basis are treated the same as other benefits under the Cafeteria Plan; they are not subject to state, federal or FICA tax.

3. How does it work? The tax-free payroll contribution funds are deposited into a selected Bank's custodial account. When a qualified expense is incurred, you simply make a Request for Reimbursement from the HSA to pay for the expense. FlexSystem will then deposit the appropriate funds into your personal bank account.

4. How does a Health Savings Account coordinate with my other benefits? Only under certain circumstances may an employee establish and fund an HSA in addition to funding a health flexible spending account. Both accounts may be funded as long as the benefits being reimbursed through the health FSA are limited to benefits or costs that may not be paid by the high deductible health plan (HDHP) itself. For example, if the HDHP does not cover dental expenses, the health FSA may be established to reimburse only these expenses.

5.What are qualified medical expenses? These are expenses such as dental care, prescriptions, eyeglasses and out-of-pocket medical expenses that may not be covered by insurance. In addition, any over-the-counter medication needed to alleviate or treat personal injuries and/or illness are eligible. However, vitamins and other dietary supplements taken for general health purposes are not eligible. For a complete list of qualified medical expenses see the IRS list.

6. Who determines the rules and regulations of FlexSystem Health Savings Accounts? Health Savings Accounts are regulated by the IRS. Our documentation guidelines are intended as a means to ensure eligibility of your claims for reimbursement. It is the Participant's responsibility to comply with these guidelines and to avoid duplication of claims or submission of ineligible charges. Failure to adhere to the above requirements could lead to payment delays or denial of expenses.

Columbus State Community College
HSA Options

Employees have the option to set up an HSA Account with the following institutions. Once you provide CSCC with the appropriate documentation, CSCC will deposit the employer's contribution into your account at each pay cycle. You may also set up additional contributions with pretax dollars via payroll deductions.

Please contact the following institutions to verify any changes to the Set-up and/or Monthly fees. This information was verified as of 01/31/13 and is subject to change. You may also want to inquire about interest rates on the HSA account.

(The institutions are listed alphabetically)

- **Education First Credit Union (previously known as MidState Educators Credit Union)**
  (614) 221-9376 ext. 109
  or 1-866-628-6446
  Web site: www.educu.org

Set-up Fee: $0.00
Monthly Fee: $0.00

- **Park National Bank**
  (740) 587-0238
  Web site: www.parknationalbank.com

Set-up Fee: $0.00
Monthly Fee: $0.00

MetLife
Metropolitan Life Insurance Company, New York, NY

ENROLLMENT • CHANGE FORM

GROUP CUSTOMER INFORMATION (To be Completed by the Recordkeeper)

Name of Group Customer/Employer	Group Customer #	Report #	Sub Code	Branch
Columbus State Community College	**147739**	**147739**	**0001**	
Date of Hire (MM/DD/YYYY)	Coverage Effective Date (MM/DD/YYYY)			

YOUR ENROLLMENT INFORMATION (To be Completed by the Employee)

Name (First, Middle, Last)		Social Security # – –	☐ Male ☐ Female
Address (Street, City, State, Zip Code)		Date of Birth (MM/DD/YYYY)	
Phone #	Email Address	☐ New Enrollment ☐ Change in Enrollment If due to a Qualifying Event, enter event date (MM/DD/YYYY)	

I have read my enrollment materials and I request coverage for the benefits for which I am or may become eligible. I understand that no contributions are required for Basic Life and Basic AD&D. I understand that contributions are required for the benefits I select below.

► If you are enrolling after the initial enrollment period, you must also complete a Statement of Health form.

Term Life Insurance

☒ Basic Life [1]

☐ Supplemental/Optional Life [1]
- ☐ 1x ☐ 2x Basic Annual Earnings up to a maximum of $340,000

☐ Dependent Spouse Life [1,2]
- ☐ $10,000 ☐ $20,000

☐ Dependent Child Life [2]

Accidental Death & Dismemberment (AD&D) Insurance

☒ Basic AD&D

☐ Voluntary AD&D

First select your option
- ☐ Employee only
- ☐ Employee + Dependents

Then select your level of coverage

Enter a multiple of $10,000 up to a maximum of $500,000. $_____

[1] Life Insurance may include an Accelerated Benefits Option under which a terminally ill insured can accelerate a portion of his or her life insurance amount. An interest and expense charge may be deducted from the accelerated payment. Receipt of accelerated benefits may affect eligibility for public assistance.

[2] Amounts will be subject to state limits, if applicable.

Dependent Information

If you are applying for coverage for your Spouse and/or Child(ren), please provide the information requested below:

Name of your Spouse (First, Middle, Last)	Date of Birth (MM/DD/YYYY)	
		☐ Male ☐ Female
Name(s) of your Child(ren) (First, Middle, Last)	**Date of Birth (MM/DD/YYYY)**	
		☐ Male ☐ Female
		☐ Male ☐ Female
		☐ Male ☐ Female
		☐ Male ☐ Female

☐ Check here if you need more lines. Provide the additional information on a separate piece of paper and return it with your enrollment form.

GEF02-1
ADM

FRAUD WARNINGS

Before signing this enrollment form, please read the warning for the state where you reside and for the state where the insurance policy under which you are applying for coverage was issued.

Arkansas, District of Columbia, Louisiana, Massachusetts, New Mexico, Ohio, Rhode Island and West Virginia: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Colorado: It is unlawful to knowingly provide false, incomplete or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

Florida: A person who knowingly and with intent to injure, defraud or deceive any insurance company files a statement of claim or an application containing false, incomplete or misleading information is guilty of a felony of the third degree.

Kentucky: Any person who knowingly and with intent to defraud any insurance company or other person files an application containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

Maine, Tennessee, Virginia and Washington: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purposes of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

Maryland: Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

New Jersey: Any person who files an application containing any false or misleading information is subject to criminal and civil penalties.

New York: [only applies to Accident and Health Benefits (AD&D/Disability/Dental)]: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to civil penalty not to exceed five thousand dollars and the stated value of the claim for each violation.

Oklahoma: WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

Oregon and Vermont: Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.

Puerto Rico: Any person who knowingly and with the intention to defraud includes false information in an application for insurance or files, assists or abets in the filing of a fraudulent claim to obtain payment of a loss or other benefit, or files more than one claim for the same loss or damage, commits a felony and if found guilty shall be punished for each violation with a fine of no less than five thousand dollars ($5,000), not to exceed ten thousand dollars ($10,000); or imprisoned for a fixed term of three (3) years, or both. If aggravating circumstances exist, the fixed jail term may be increased to a maximum of five (5) years; and if mitigating circumstances are present, the jail term may be reduced to a minimum of two (2) years.

Pennsylvania and all other states: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

GEF09-1
FW

BENEFICIARY DESIGNATION FOR EMPLOYEE INSURANCE

Note: Dependent insurance is payable to the Employee.
If you have previously designated a beneficiary under this Group Customer's plan, such beneficiary designation will remain in effect. Any MetLife payment upon your death will be paid in accordance with the records of the recordkeeper for such insurance unless you designate a beneficiary below.
I designate the following person(s) as primary beneficiary(ies) for any MetLife payment upon my death.
I understand I have the right to change this designation at any time.

Primary Beneficiary Full Name (Last, First, Middle Initial)	Relationship	Date of Birth (MM/DD/YYYY)	Address (Street, City, State, Zip Code)	Share %
Unless otherwise indicated, payment will be made in equal shares to your surviving Primary Beneficiary(ies).			**TOTAL:**	**100%**

If all of the Primary Beneficiary(ies) die before me, I designate as Contingent Beneficiary(ies):

Contingent Beneficiary Full Name (Last, First, Middle Initial)	Relationship	Date of Birth (MM/DD/YYYY)	Address (Street, City, State, Zip Code)	Share %
Unless otherwise indicated, payment will be made in equal shares to your surviving Contingent Beneficiary(ies).			**TOTAL:**	**100%**

DECLARATIONS AND SIGNATURE

By signing below, I acknowledge:

1. I have read this enrollment form and declare that all information I have given is true and complete to the best of my knowledge and belief.
2. I declare that I am actively at work on the date I am enrolling and, if I am enrolling for any contributory life insurance, that I was actively at work for at least 20 hours during the 7 calendar days preceding my date of enrollment. I understand that if I am not actively at work on the scheduled effective date of insurance, such insurance will not take effect until I return to active work.
3. I understand that, on the date dependent insurance for a person is scheduled to take effect, the dependent must not be confined at home under a physician's care, receiving or applying for disability benefits from any source, or Hospitalized. If the dependent does not meet this requirement on such date, the insurance will take effect on the date the dependent is no longer confined, receiving or applying for disability benefits from any source, or Hospitalized.
4. I understand that if I do not enroll for life coverage during the initial enrollment period, or if I do not enroll for the maximum amount of coverage for which I am eligible, evidence of insurability satisfactory to MetLife may be required to enroll for or increase such coverage after the initial enrollment period has expired. Coverage will not take effect, or it will be limited, until notice is received that MetLife has approved the coverage or increase.
5. I authorize my employer to deduct the required contributions from my earnings for my coverage. This authorization applies to such coverage until I rescind it in writing.
6. I have read the Beneficiary Designation section provided in this enrollment form and I have made a designation if I so choose.
7. I have read the applicable Fraud Warning(s) provided in this enrollment form.

Signature of Employee	Print Name	Date Signed (MM/DD/YYYY)

GEF09-1
DEC

INSTRUCTIONS

FOR THE **STATEMENT OF HEALTH** FORM AND THE **AUTHORIZATION** FORM THAT FOLLOW THIS SECTION

INSTRUCTIONS TO THE RECORDKEEPER (The Recordkeeper may be the Group Customer, a Third Party Administrator or MetLife.)

1. Fill in the Group Customer Information and Insurance Information on the Statement of Health form.
2. Give the forms to the Employee.

INSTRUCTIONS TO THE EMPLOYEE

1. Fill in your name and Social Security # on the Statement of Health form. The Employee's Name and the Employee's Social Security # must appear on the form.
2. Give the forms to the Proposed Insured to complete and send to MetLife.

INSTRUCTIONS TO THE PROPOSED INSURED (The Proposed Insured is the person for whom insurance is being requested. The Proposed Insured may be the Employee, the Employee's Spouse or the Employee's Child.) A separate Statement of Health form must be completed by each Proposed Insured. Based on the enrollment form submitted by the Employee, a Statement of Health form is required to complete the employee's request for group insurance coverage for you, the Proposed Insured.

1. If the Insurance Information Section is not completed, obtain the information before finalizing the form. Contact your Employer/Benefits Administrator if the Life Insurance amounts were not provided or to confirm the Life Insurance amounts.
2. Complete the Statement of Health form and sign where indicated by an arrow.
3. Sign the Authorization form where indicated by an arrow.
4. After completion, make a copy of both completed forms for your records and FAX, MAIL or EMAIL the original forms to the address at the right. Emailed forms must be printed and signed before they are scanned and submitted.

For questions, call MetLife at 1-800-638-6420, prompt 1 (Statement of Health Unit) or email us at eoi@metlife.com.

Metropolitan Life Insurance Company
Statement of Health Unit
P.O. Box 14069
Lexington, KY 40512-4069
FAX: 1-859-225-7909

To Submit Completed Forms Email:
SOHSubmissions@metlife.com

For Questions Email: eoi@metlife.com

Note: Additional medical information may be required after MetLife's initial review of a completed Statement of Health form. The additional information requested may be a physical examination, paramedical exam, or an Attending Physician Report. Correspondence will be sent within ten days by MetLife or our approved vendor. Incomplete forms will be returned to you for completion.

Some services in connection with your Statement of Health form may be performed by our affiliate, MetLife Global Operations Support Center Private Limited. This service arrangement in no way alters Metropolitan Life Insurance Company's obligations to you. Services will not be performed by our affiliate if prohibited by state or local law or by mutual agreement with the Group Customer.

STATEMENT OF HEALTH FORM

MetLife
Metropolitan Life Insurance Company, New York, NY

GROUP CUSTOMER INFORMATION (To be Completed by the Recordkeeper)

Name of Group Customer/Employer/Association		Group Customer #	Reporting Location #
Columbus State Community College		**147739**	
Street Address	City	State	Zip Code
550 East Spring Street	Columbus	OH	43215-1722

INSURANCE INFORMATION (To be Completed by the Recordkeeper)

Enrollment year 2014

Term Life Insurance

- ☒ Basic Life: Indicate amount subject to medical underwriting $_____
- ☐ Supplemental/Optional Life: Indicate amount subject to medical underwriting $_____
- ☐ Dependent Spouse [1] Life: Indicate amount subject to medical underwriting $_____
- ☐ Dependent Child Life: Indicate amount subject to medical underwriting $_____

EMPLOYEE INFORMATION (To be Completed by the Employee)

Name of Employee (First, Middle, Last)	Social Security # of Employee

YOUR INFORMATION (To be Completed by the Proposed Insured)

Name (First, Middle, Last)			Relationship to Employee ☐ Self ☐ Spouse ☐ Child	☐ Male ☐ Female
Street Address		City	State	Zip Code
Date of Birth (MM/DD/YYYY)	Daytime Phone #	Home Phone #	Email Address	

[1] For Vermont and Washington State residents, Spouse includes your registered Domestic Partner if you and your Domestic Partner are registered as domestic partners, civil union partners or reciprocal beneficiaries with a government agency or office where such registration is available.

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ADM

Please complete all sections of this form. Incomplete forms will be returned to you.

HEALTH INFORMATION

SECTION 1

Please complete all questions below. Omitted information will cause delays. In this section, "you" and "your" refers to the person for whom insurance is being requested. Health Information is required for the Proposed Insured only. For questions 5 through 11u, for "yes" answers, please provide full details in Section 2.

Your name _____ Employee's Name _____

Employee's Social Security/Identification # _____

	Yes	No
1. Your height ___ feet ___ inches Your weight ____ pounds		
2. Are you now on a diet prescribed by a physician or other health care provider? If "yes" indicate type _____	☐	☐
3. Are you now pregnant? If "yes," what is your due date (month/day/year)? _____	☐	☐
If "yes", provide Physician's name _____ Telephone: (_____) _____ – _____		
4. Are you now, or have you in the past 2 years, used tobacco in any form?	☐	☐
5. In the past 5 years, have you received medical treatment or counseling by a physician or other health care provider for, or been advised by a physician or other health care provider to discontinue, the use of alcohol or prescribed or non-prescribed drugs?	☐	☐
6. In the past 5 years, have you been convicted of driving while intoxicated or under the influence of alcohol and/or any drug? If "yes", specify "date(s) of conviction(s) (month/day/year) _____	☐	☐
7. Have you had any application for life, accidental death and dismemberment or disability insurance ☐ declined ☐ postponed ☐ withdrawn ☐ rated ☐ modified or ☐ issued other than as applied for? Indicate reason _____	☐	☐
8. Are you now receiving or applying for any disability benefits, including workers' compensation?	☐	☐
9. Have you been **Hospitalized** as defined below (not including well-baby delivery) in the past 90 days? **Hospitalized** means admission for inpatient care in a hospital; receipt of care in a hospice facility, intermediate care facility, or long term care facility; or receipt of the following treatment wherever performed: chemotherapy, radiation therapy, or dialysis.	☐	☐
10. Have you ever been diagnosed or treated by a physician or other health care provider for Acquired Immunodeficiency Syndrome (AIDS), AIDS Related Complex (ARC) or the Human Immunodeficiency Virus (HIV) infection?	☐	☐
11. Have you ever been diagnosed, treated or given medical advice by a physician or other health care provider for:		
a. cardiac or cardiovascular disorder? Indicate type _____	☐	☐
b. stroke or circulatory disorder? Indicate type _____	☐	☐
c. high blood pressure?	☐	☐
d. cancer, Hodgkin's disease, lymphoma or tumors? Indicate type _____	☐	☐
e. anemia, leukemia or other blood disorder? Indicate type _____	☐	☐
f. diabetes? Your age at diagnosis? _____ ☐ Check if insulin treated	☐	☐
g. asthma, COPD, emphysema or other lung disease? Indicate type _____	☐	☐
h. ulcers, stomach, hepatitis or other liver disorder? Indicate type _____	☐	☐
i. colitis, Crohn's, diverticulitis or other intestinal disorder? Indicate type _____	☐	☐
j. memory loss? Indicate type _____	☐	☐
k. epilepsy, paralysis, seizures, dizziness or other neurological disorder? Specify date of last seizure (month/year) _____ Indicate type _____	☐	☐
l. Epstein-Barr, chronic fatigue syndrome or fibromyalgia? Indicate type _____	☐	☐
m. multiple sclerosis, ALS or muscular dystrophy? Indicate type _____	☐	☐
n. lupus, scleroderma, auto immune disease or connective tissue disorder?	☐	☐
o. arthritis? ☐ osteoarthritis ☐ rheumatoid ☐ other/type _____	☐	☐
p. back, neck, knee, spinal, joint or other musculoskeletal disorder? Indicate type _____	☐	☐
q. carpal tunnel syndrome?	☐	☐
r. kidney, urinary tract or prostate disorder? Indicate type _____	☐	☐
s. thyroid or other gland disorder? Indicate type _____	☐	☐
t. mental, anxiety, depression, attempted suicide or nervous disorder? Indicate type _____	☐	☐
u. sleep apnea? Indicate type _____	☐	☐

After completing the Personal Physician and Prescription Information on the next page, please provide full details in Section 2 for "yes" answers to questions 5 through 11u.

Personal Physician Information

Personal Physician's Name: _____

Address (Street, City, State, Zip Code): _____ Telephone: (____) ____–____

Date of last visit (MM/DD/YYYY): __/__/____ Reason for visit: _____

Prescription Information

Are you currently taking any prescribed medications? ☐ Yes ☐ No If yes, list the medications.

Medication: _____ Condition/Diagnosis: _____

Prescribing Physician's Name: _____ Telephone: (____) ____–____

Address (Street, City, State, Zip Code): _____

Medication: _____ Condition/Diagnosis: _____

Prescribing Physician's Name: _____ Telephone: (____) ____–____

Address (Street, City, State, Zip Code): _____

☐ Check here if you are attaching another sheet for any additional medications.

SECTION 2

Please provide full details below for each "Yes" answer to questions 5 through 11u in Section 1. If you need more space to provide full details, attach a separate sheet with the information and sign and date it. Delays in processing your application may occur if complete details are not provided. MetLife may contact you for additional or missing information. ☐ Check here if you are attaching another sheet.

Your name _____ Employee's Name _____

Your Date of Birth __/__/____

Question Number	Condition/Diagnosis	Please list any medication prescribed that you did not already identify in the Prescription Information above.
Date of Diagnosis (Month/Year)	Date of Last Treatment (Month/Year)	Type of Treatment

Treating Health Professional

Physician's Name: _____

Date of last visit: _____ Reason for visit: _____

Address _____

Street City State Zip Code

Telephone: (____) ____-____

Question Number	Condition/Diagnosis	Please list any medication prescribed that you did not already identify in the Prescription Information above.
Date of Diagnosis (Month/Year)	Date of Last Treatment (Month/Year)	Type of Treatment

Treating Health Professional

Physician's Name: _____

Date of last visit: _____ Reason for visit: _____

Address _____

Street City State Zip Code

Telephone: (____) ____-____

Question Number	Condition/Diagnosis	Please list any medication prescribed that you did not already identify in the Prescription Information above.
Date of Diagnosis (Month/Year)	Date of Last Treatment (Month/Year)	Type of Treatment

Treating Health Professional

Physician's Name: _____

Date of last visit: _____ Reason for visit: _____

Address _____

Street City State Zip Code

Telephone: (____) ____-_____

GEF09-1
HEA

FRAUD WARNINGS

Before signing this Statement of Health form, please read the warning for the state where you reside and for the state where the contract under which you are applying for coverage was issued.

Alabama, Arkansas, District of Columbia, Louisiana, Massachusetts, New Mexico, Ohio, Rhode Island and West Virginia: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Colorado: It is unlawful to knowingly provide false, incomplete or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

Florida: Any person who knowingly and with intent to injure, defraud or deceive any insurance company files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony of the third degree.

Kentucky: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

Maine, Tennessee, Virginia and Washington: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

Maryland: Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

New Jersey: Any person who files an application containing any false or misleading information is subject to criminal and civil penalties.

New York (only applies to Accident and Health Benefits): Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

Oklahoma: WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

Oregon and Vermont: Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.

Puerto Rico: Any person who knowingly and with the intention to defraud includes false information in an application for insurance or files, assists or abets in the filing of a fraudulent claim to obtain payment of a loss or other benefit, or files more than one claim for the same loss or damage, commits a felony and if found guilty shall be punished for each violation with a fine of no less than five thousand dollars ($5,000), not to exceed ten thousand dollars ($10,000); or imprisoned for a fixed term of three (3) years, or both. If aggravating circumstances exist, the fixed jail term may be increased to a maximum of five (5) years; and if mitigating circumstances are present, the jail term may be reduced to a minimum of two (2) years.

Pennsylvania and all other states: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

GEF09-1
FW

Please complete all sections of this form. Incomplete forms will be returned to you.

DECLARATIONS AND SIGNATURES

By signing below, I acknowledge:

1. I have read this Statement of Health form and declare that all information I have given, including any health information, is true and complete to the best of my knowledge and belief. I understand that this information will be used by MetLife to determine my insurability.
2. I have read the applicable Fraud Warning(s) provided in this Statement of Health form.

Sign Here

Signature of Proposed Insured	Print Name	Date Signed (MM/DD/YYYY)

If a child proposed for insurance is age 18 or over, the child must sign this Statement of Health. If the child is under age 18, a Personal Representative for the child must sign, **and indicate the legal relationship between the Personal Representative and the proposed insured**. A Personal Representative for the child is a person who has the right to control the child's health care, usually a parent, legal guardian, or a person appointed by a court.

Sign Here

Signature of Personal Representative	Print Name	Date Signed (MM/DD/YYYY)

Relationship of Personal Representative

GEF09-1
DEC

Please complete all sections of this form. Incomplete forms will be returned to you.

AUTHORIZATION

This Authorization is in connection with an enrollment in group insurance and information required for underwriting and claim purposes for the proposed insured(s) ("employee", spouse, and /or any other person(s) named below). Underwriting means classification of individuals for determination of insurability and / or rates, based upon physician health reports, prescription drug history, laboratory test results, and other factors. Notwithstanding any prior restriction placed on information, records or data by a proposed insured, each proposed insured hereby authorizes:

- Any medical practitioner, facility or related entity; any insurer; MIB Group, Inc ("MIB"); any employer; any group policyholder, contract holder or benefit plan administrator; any pharmacy or pharmacy related service organization; any consumer reporting agency; or any government agency to give Metropolitan Life Insurance Company ("MetLife") or any third party acting on MetLife's behalf in this regard:
  - personal information and data about the proposed insured including employment and occupational information;
  - medical information, records and data about the proposed insured including information, records and data about drugs prescribed, medical test results and sexually transmitted diseases;
  - information, records and data about the proposed insured related to alcohol and drug abuse and treatment, including information and data records and data related to alcohol and drug abuse protected by Federal Regulations 42 CFR part 2;
  - information, records and data about the proposed insured relating to Acquired Immunodeficiency Syndrome (AIDS) or AIDS related conditions including, where permitted by applicable law, Human Immunodeficiency Virus (HIV) test results;
  - information, records and data about the proposed insured relating to mental illness, except psychotherapy notes; and
  - motor vehicle reports.

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

Expiration, Revocation and Refusal to Sign: This authorization will expire 24 months from the date on this form or sooner if prescribed by law. The proposed insured may revoke this authorization at any time. To revoke the authorization, the proposed insured must write to MetLife at P.O. Box 14069, Lexington, KY 40512-4069, and inform MetLife that this Authorization is revoked. Any action taken before MetLife receives the proposed insured's revocation will be valid. Revocation may be the basis for denying coverage or benefits. If the proposed insured does not sign this Authorization, that person's enrollment for group insurance cannot be processed.

By signing below, each proposed insured acknowledges his or her understanding that:

- All or part of the information, records and data that MetLife receives pursuant to this authorization may be disclosed to MIB. Such information may also be disclosed to and used by any reinsurer, employee, affiliate or independent contractor who performs a business service for MetLife on the insurance applied for or on existing insurance with MetLife, or disclosed as otherwise required or permitted by applicable laws.
- Medical information, records and data that may have been subject to federal and state laws or regulations, including federal rules issued by Health and Human Services, setting forth standards for the use, maintenance and disclosure of such information by health care providers and health plans and records and data related to alcohol and drug abuse protected by Federal Regulations 42 CFR part 2, once disclosed to MetLife or upon redisclosure by MetLife, may no longer be covered by those laws or regulations.
- Information relating to HIV test results will only be disclosed as permitted by applicable law.
- Information obtained pursuant to this authorization about a proposed insured may be used, to the extent permitted by applicable law, to determine the insurability of other family members.
- A photocopy of this form is as valid as the original form. Each proposed insured has a right to receive a copy of this form.
- I authorize MetLife, or its reinsurers, to make a brief report of my personal health information to MIB.

Sign Here

Signature of Proposed Insured		Date Signed (MM/DD/YYYY)
Print Name	State of Birth	Country of Birth

If a child proposed for insurance is age 18 or over, the child must sign this Authorization form. If the child is under age 18, a Personal Representative for the child must sign, **and indicate the legal relationship between the Personal Representative and the proposed insured**. A Personal Representative for the child is a person who has the right to control the child's health care, usually a parent, legal guardian, or a person appointed by a court.

Sign Here

Signature of Personal Representative	Print Name	Date Signed (MM/DD/YYYY)
Relationship of Personal Representative		

MetLife
Metropolitan Life Insurance Company, New York, NY

ENROLLMENT • CHANGE FORM

GROUP CUSTOMER INFORMATION (To be Completed by the Recordkeeper)

Name of Group Customer/Employer	Group Customer #	Report #	Sub Code	Branch
Columbus State Community College	**147739**	**147739**		
Date of Hire (MM/DD/YYYY)	Coverage Effective Date (MM/DD/YYYY)			

YOUR ENROLLMENT INFORMATION (To be Completed by the Employee)

Name (First, Middle, Last)		Social Security # – –	☐ Male ☐ Female
Address (Street, City, State, Zip Code)		Date of Birth (MM/DD/YYYY)	
Phone #	Email Address	☐ New Enrollment ☐ Change in Enrollment If due to a Qualifying Event, enter event date (MM/DD/YYYY)	

I have read my enrollment materials and I request coverage for the benefits for which I am or may become eligible. I understand that no contributions are required for Long Term Benefits.

Disability Income Insurance

☒ Long Term Benefits

GEF02-1
ADM

FRAUD WARNINGS

Before signing this enrollment form, please read the warning for the state where you reside and for the state where the contract under which you are applying for coverage was issued.

Alabama, Arkansas, District of Columbia, Louisiana, Massachusetts, New Mexico, Ohio, Rhode Island and West Virginia: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Colorado: It is unlawful to knowingly provide false, incomplete or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

Florida: Any person who knowingly and with intent to injure, defraud or deceive any insurance company files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony of the third degree.

Kentucky: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

Maine, Tennessee, Virginia and Washington: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

Maryland: Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

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FW

SUBMISSION INSTRUCTIONS

After completion, make a copy for your records and return the original to your Employer.

New Jersey: Any person who files an application containing any false or misleading information is subject to criminal and civil penalties.

New York (only applies to Accident and Health Benefits): Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

Oklahoma: WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

Oregon and Vermont: Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.

Puerto Rico: Any person who knowingly and with the intention to defraud includes false information in an application for insurance or files, assists or abets in the filing of a fraudulent claim to obtain payment of a loss or other benefit, or files more than one claim for the same loss or damage, commits a felony and if found guilty shall be punished for each violation with a fine of no less than five thousand dollars ($5,000), not to exceed ten thousand dollars ($10,000); or imprisoned for a fixed term of three (3) years, or both. If aggravating circumstances exist, the fixed jail term may be increased to a maximum of five (5) years; and if mitigating circumstances are present, the jail term may be reduced to a minimum of two (2) years.

Pennsylvania and all other states: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

GEF09-1
FW

DECLARATIONS AND SIGNATURE

By signing below, I acknowledge:

1. I have read this enrollment form and declare that all information I have given is true and complete to the best of my knowledge and belief.
2. I declare that I am actively at work on the date I am enrolling.
3. I have read the applicable Fraud Warning(s) provided in this enrollment form.

Sign Here

Signature of Employee	Print Name	Date Signed (MM/DD/YYYY)

GEF09-1
DEC

FlexSystem™

TASC™

Flexible Spending Account Enrollment Form

Client TASC Id:
4901-4755-9523
Plan Name:
Columbus State Community College

TWILA WILEY
COLUMBUS STATE COMMUNITY COLLEGE
PO BOX 88278
COLUMBUS OH 43216

Every line must be completed. Please enter zero (0) on the lines where no amount is being deducted. Make sure to sign and date the enrollment form. Return the completed and signed form to your employer.

Participant Information: Full Name _____
Address _____
City_____ State _____ Zip _____
Email _____
Home Phone Number _____
Mobile Phone Number _____
Participant's Plan Effective Date _____
Date of First Payroll _____

Prior to completing your election amounts, refer to the instructions and frequently asked questions on page 2.

Benefit	Max. Employee Salary Reduction	Annual Salary Reduction Election
Medical (Out-of-Pocket) Expenses	$ 2,500.00	$ _____
Dependent Care Expenses	$ 5,000.00	$ _____
Non-Employer Sponsored Premiums	No Maximum	$ _____
Transit Expenses	$ 1,560.00	$ _____

Additional TASC Card for Spouse or Dependent

Each participant may receive one additional card for their spouse or dependent free of charge. To request an additional TASC Card for your spouse or dependent, print their name below. Cards are mailed to your home address 7 – 10 days after your enrollment has been updated in FlexSystem.

Spouse or Dependent Name (Last, First, MI): _____

AUTHORIZATION: I certify the above information to be true to the best of my knowledge and that the children for whom I will be claiming dependent or child care expenses either reside with me in a parent-child relationship or are legally dependent on me for their support. I agree to have my compensation reduced by the deduction amount(s) stated above. I understand amounts remaining in my flexible spending account(s) not used for qualified expenses incurred during the plan year will be forfeited in accordance with current plan provisions and tax laws. I further understand the Flexible Spending Amount will be in effect for the entire plan year and cannot be changed or revoked except as permitted by federal law. I understand my share of eligible group premium(s) will be automatically deducted before taxes. I also understand, that if I do not wish to have my eligible insurance contributions deducted pre-tax and prefer to be taxed on these dollars, I will contact my payroll department. I understand additional TASC Cards issued to my spouse or dependent will provide the named individual with access to my flexible spending account(s) and MyCash account. I accept all responsibility for card transactions incurred by the named individual and will submit supporting documentation, as requested, for those transactions. I agree that upon inappropriate or fraudulent use of the TASC Card or termination of employment, I will immediately return all TASC Cards to my Employer.

Authorize Signature_____ Date: _____

Enrollment Form Instructions

Medical (Out-of-Pocket) Expenses: This amount is usually paid toward deductible and co-insurance portions of health insurance, dental expenses, orthodontic expenses, eyecare and other miscellaneous health care expenses per year. After determining the per payroll amount, multiply that number by the number of payrolls to determine your annual election.

Dependent Care Expenses: Amount paid for day care expenses per year. The maximum allowable amount under IRS regulations is $5,000 per calendar year per family; $2,500 per calendar year for married individuals filing single.

Non-Employer Sponsored Premiums: Privately purchased insurance premiums, including health, disability, cancer and term life insurance. Group insurance premiums deducted from your paycheck for your employer-sponsored plans DO NOT qualify within this category. Insurance premiums deducted through your spouse's employer are not eligible.

Pre-Tax Example

	Without FlexSystem	With FlexSystem
Gross Pay	$3,500/mo	$3,500/mo
Pre-Tax Benefits		
-Medical/Dental Premiums	0	300
-Medical Expenses	0	100
-Dependent Care Expenses	0	400
TOTAL	0	800
Wages subject to tax	3,500	2,700
Federal Tax	525	405
FICA Tax (Social Security)	268	207
State Tax	175	135
Out-of-Pocket expenses	800	0
Spendable Income	1,732	1,953

Net Increase in Take-Home Pay = $221/mo

This is an illustration only and actual numbers may vary. Paying certain qualified expenses before tax increases your take-home pay.

Questions Frequently Asked by Employees

1. What does FlexSystem offer?

FlexSystem offers you a choice to pay for certain qualified benefits on a pre-tax basis Paying for certain benefits with pre-tax dollars reduces the amount you pay in taxes and increases your take-home pay. Every dollar paid on a pre-tax basis results in a savings to you. (See example in box.)

2. Any cost or fee to me?

No.

3. Must I participate in my employer's health insurance?

FlexSystem is not tied to any insurance plan or company. You may participate in FlexSystem regardless of your particular insurance provider.

4. What are qualified medical expenses?

These expenses include dental care, prescriptions, eyeglasses, and out-of-pocket medical expenses not covered by insurance. However, vitamins and other dietary supplements taken for general health purposes are not eligible. Purchases of over-the-counter (OTC) medicines and drugs (with the exception of insulin) are only reimbursable if accompanied by a prescription or Prescription Order Form from your medical practitioner. Below are some ***examples*** of health related expenses:

OTC items that require a prescription or Prescription Order Form include the following:

Acid Controllers	Anti-Itch and Insect Bite	Digestive Aids	Pain Relief
Allergy and Sinus	Antiparasitic Treatments	Feminine Anti-Fungal/Anti-Itch	Respiratory Treatments
Antibiotic Products	Baby Rash Ointments and Creams	Hemorrhoidal Medications	Sleep Aids and Sedatives
Anti-Gas and Diarrhoea	Cough, Cold and Flu	Laxatives	Stomach Remedies

OTC items that are eligible and need no physician authorization include the following:

Bandages & First Aid Dressings	Contact Lens Solution	Heating Pads	Orthopedic Aids
Birth Control Products	Denture Products	Hot, Cold & Steam Packs	Pregnancy & Fertility Kits
Blood Pressure Kits	Diabetes Testing Supplies	Incontinence Products	Splints, Supports & Braces
Canes and Walkers	Durable Medical Equipment	Insulin	Thermometers
Contact Lenses	Hearing Aid Batteries	Nebulizers	Wheel & Accessories

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5. How does the Dependent Care Account compare with the tax credit available on the individual Form 1040?

The circumstances that determine which option offers greater savings vary from family to family; as such, the decision to choose the tax credit or the dependent care deduction may be made on a case by case basis only. Participation in FlexSystem results in an immediate savings on Federal, State and Social Security tax, whereas the Federal credit will affect Federal Income Tax only and will be taken at year-end.

6. How does a Cafeteria Plan affect Social Security benefits?

Reduction of your Social Security benefits will be minimal and is offset by the tax savings and lower health care costs available under FlexSystem. To compensate for this minimal reduction you may consider increasing your retirement plan funding.

7. Under what circumstances can the annual election be changed?

The elections can be changed only if there is a change in family or employment status. See the "Change of Elections Form" for more details.

8. What is the "Use-It-or-Lose-It" rule?

Any funds left unused at the end of the Plan Year are forfeitured. Take precautionary steps to avoid having balances in the Flexible Spending Accounts at year-end. The key is to be conservative when making elections.

9. Who determines the rules and regulations of FlexSystem?

Flexible Spending Accounts are regulated by the IRS. Our documentation guidelines are intended as a means to ensure eligibility of your Requests for Reimbursement. It is the participant's responsibility to comply with these guidelines and to avoid duplication of requests or submission of ineligible charges. Failure to adhere to the above requirement could lead to payment delays or denial of expenses.

In the event of an error or omission in the course of administering the Plan on behalf of the employer and participating employees, TASC will notify and remedy the error or omission within a reasonable period of time following the error or omission. The employer and employees agree to TASC's procedures for making any corrections, including but not limited to payroll reduction. An error by the employer or TASC does not constitute an assumption of liability for the amount of the error.

Medical Plan Summary-HDHP/HSA

Benefit	**In Network**
Deductible-Single Deductible-Family	$2,500 $5,000
Coinsurance	90%/10%
Out of Pocket-Single Out of Pocket-Family	$3,000 $6,000
Office Visit-PCP Office Visit-Specialist Urgent Care Emergency Room	Deductible then 10%
Preventive Services	Covered at 100%
Preventive Prescriptions (not subject to deductible) Retail Mail Order	$10 Tier 1/ $30 Tier 2/ $80 Tier 3 $20 Tier 1/ $60 Tier 2/ $160 Tier 3
Prescriptions-Retail (after deductible) Prescriptions- Mail (90 day supply)	$10 Tier 1/ $30 Tier 2/ $80 Tier 3 $20 Tier 1/ $60 Tier 2/ $160 Tier 3

With Healthy Rewards

80%/20% Monthly	HDHP/HSA
Single	$98.40
Family	$258.76

Without Healthy Rewards

70%/30% Monthly	HDHP/HSA
Single	$147.60
Family	$388.14

Medical Plan Summary- Core/PPO

Benefit	**In Network**
Deductible-Single Deductible-Family	$500 $1,000
Coinsurance	80%/20%
Out of Pocket-Single Out of Pocket-Family	$4,500 $9,000
Preventive Care	Covered at 100%
Office Visit-PCP Office Visit-Specialist	$20 copay $30 copay
Impatient Hospital	20% after deductible
Outpatient Hospital	20% after deductible
Emergency Room	$250
Urgent Care	$35
Lifetime Maximum	Unlimited
Prescriptions-Retail (after deductible) Prescriptions- Mail (90 day supply)	$10 Tier 1/ $30 Tier 2/ $80 Tier 3 $20 Tier 1/ $60 Tier 2/ $160 Tier 3

With Healthy Rewards

80%/20% Monthly	CORE/PPO
Single	$106.60
Family	$280.34

Without Healthy Rewards

70%/30% Monthly	CORE/PPO
Single	$159.90
Family	$420.52

Vision Plan

Vision Service Plan Summary

Benefit Feature	Network Benefit Level
Eye Exam	**One every calendar year by a VSP provider $10 copay**
Lenses (Per Pair)	**Single vision, lined bifocal and lined trifocal lenses are covered with a $25 copay every calendar year from a VSP provider**
Frame	**Covered up to $130.00 allowance once very other calendar year from a VSP provider**
Contact Lenses (Per Pair, in lieu of lenses/frames)	**Covered up to $135.00 allowance once every calendar year from a VSP provider**

VSP Plan Type	Monthly Premium
Single	$2.92
Family	$8.05

Dental Plan Summary

Benefit Feature	Delta PPO
Deductible	**None**
Annual Maximum	**$1,500 per person**
Preventive Services	**100%**
Minor/Basic Services	**90%**
Major Services	**60%**
Orthodontia	**$1,000 lifetime max children to age 19**

Delta Dental PPO	Monthly Premium
Single	$6.87
Family	$19.69

CSCC Incentive Structure

UnitedHealthcare

Incented Health Activities	Points	Maximum Points
Eligible Members: Employees and Spouses		
Health Assessment	2 points	2 points
Complete Annual Preventive Exam	1 point	1 point
Complete Biometric Screening or Lab Panel	2 points	2 points
Screenings (Cervical, Colorectal, Mammogram, Prostate), Bone Density, Flu Immunization	1 point each	3 points
Online Coaching Completion	1 point each	2 points
Living With Illness completion of program (Asthma, Diabetes, Coronary Artery Disease, Heart Failure, COPD, Healthy Pregnancy)	2 points	2 points
Diabetes Prevention and Control Completion	2 points	2 points
Preventive Dental Screenings	2 points	2 points
Preventive Dental Screenings – 2nd visit	1 point	1 point

Healthy Rewards

Important reminders about your

Annual Wellness Visit

- **When scheduling your Annual Visit, please let your physician know that it should include the following:**
  - **Full Lipid Panel**
  - **Hgb A1c- <u>may be *recommended*</u> based on your Diabetes Risk Score**
  - **Blood Pressure check**
  - **Body Mass Index (BMI) - If your physician does not calculate the BMI, don't worry, there is a tool on myuhc.com.**

    - **Simply log onto myuhc.com**
    - **Click on Health & Wellness (upper right corner)**
    - **Click on BMI Calculator (half way down the left side)**
    - **Enter your height and weight and click calculate**

Age Appropriate Preventive Care

- **Mammography – Adult women of standard risk every one to two years beginning at age 40 or as directed by your physician.**
- **Cervical Cancer Screening – Every 2 years beginning at age 21**
- **Colorectal Screening – Routine screening beginning at age 50**
- **Prostate Cancer Screening – Men 40 and older consult with your physician regarding screening benefits**
- **Bone Density- Routine screening recommended for women age 65 and older. Screening for post-menopausal women at defined high risk, discuss with your physician.**
- **Flu Shot**

Because We Care!!!

How to Get ID Cards

UnitedHealthcare
Healing health care. Together.

A personalized medical ID card will be mailed to your home within three weeks from your effective date. You may request additional copies online. Follow the steps below to register.

1. Visit www.myuhc.com
2. Select Register Now
3. Type in Requested Information
4. Get Started

You may also call United Healthcare's customer service at (866) 734-7670 (HDHP/HSA) or (866) 844-4864 (PPO/Core).

DELTA DENTAL

Dental cards are not mailed to your home but you may request one online. To register follow the steps below.

1. Visit www.deltadentaloh.com
2. Select Consumer Toolkit
3. Register Now
4. Type in Requested Information
5. Get Started

You may also call Delta Dental's customer service at 800-282-0749

vsp
Vision care for life

Vision cards are not mailed to your home but you may request one online. To register follow the steps below.

1. Visit vsp.com
2. Select Members
3. Register Now
4. Type in Requested Information
5. Get Started

You may also call VSP's customer service at 800.877.7195

HIPAA Special Enrollment Notice

HIPAA Special Enrollment Rights

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself or your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing towards your or your dependents' other coverage). However, you must request enrollment within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

In addition, if you have a new dependent as result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must enroll within 30 days after the marriage, birth, adoption, or placement for adoption.

Effective April 1, 2009 special enrollment rights also exist in the following circumstances: ***In the two below listed circumstances only, you or your dependents will have sixty (60) days to request special enrollment or disenrollment in the group health plan coverage.***

- If you or your dependents experience a loss of eligibility for Medicaid or your State Children's Health Insurance Program (SCHIP) coverage; or
- If you or your dependents become eligible for premium assistance under an optional state Medicaid or SCHIP program that would pay the employee's portion of the health insurance premium.

To request special enrollment or obtain more information, contact:

Monessa Bradford
614-287-2107
Or a Human Resources Representative

INDIVIDUAL **CREDITABLE** COVERAGE DISCLOSURE NOTICE OMB 0938-0990

Important Notice from Columbus State Community College About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Columbus State Community College and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

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

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

2. UnitedHealthcare-Optum has determined that the prescription drug coverage offered by the Columbus State Community College 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 November 15th to December 31st.

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.

CMS Form 10182-CC Updated April 1, 2011 According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0990. The time required to complete this information collection is estimated to average 8 hours per response initially, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

INDIVIDUAL **CREDITABLE** COVERAGE DISCLOSURE NOTICE OMB 0938-0990

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 State Community College coverage will not be affected. Once you become eligible for Medicare Part D you may keep this coverage and this plan will coordinate with Part D coverage.
Medicare Part D Eligible Individuals may refer to http://www.cms.hhs.gov/CreditableCoverage, which outlines the prescription drug plan provisions/options that Medicare eligible individuals may have available to them when they become eligible for Medicare Part D.

If you do decide to join a Medicare drug plan and drop your current Columbus State Community College coverage, be aware that you and your dependents will only be able to get this coverage back during open enrollment as long as you are a full time benefit eligible employee.

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 [Insert Name of Entity] and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

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

For More Information About This Notice Or Your Current Prescription Drug Coverage…

Contact the person listed below for further information UnitedHealthCare-Optum] at (866) 314-0335. **NOTE:** You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through Columbus State Community College changes. You also may request a copy of this notice at any time.

CMS Form 10182-CC Updated April 1, 2011 According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0990. The time required to complete this information collection is estimated to average 8 hours per response initially, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

INDIVIDUAL **CREDITABLE** COVERAGE DISCLOSURE NOTICE OMB 0938-0990

For More Information About Your Options Under Medicare Prescription Drug Coverage…

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

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

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

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

Date: April 1, 2011
Name of Entity/Sender: Columbus State Community College
Contact: Human Resources
Address: 550 E Spring St. P.O. Box 1609 RH
Columbus, OH 43216
Phone Number: 614-287-2408

2014 Preventive Drug List for Consumer Driven Health Plans Expanded List

UnitedHealthcare®

Alphabetical Listing – Expanded List

A

abacavir
Abilify
acarbose
Accolate
Accuneb
Accupril
Accuretic
acebutolol
Aceon
Actonel
ACTOplus met
ACTOplus met XR
Actos **E**
Adalat CC
Advair Diskus
Advair HFA
Advicor
Aerobid
Afeditab
Aggrenox
albuterol nebulized solution
albuterol oral tablet
Aldactazide
Aldactone
alendronate
Altace
Altoprev **E**
Alvesco
Amaryl
amiloride
amiloride-hydrochlorothiazide
aminophylline
amlodipine
amlodipine-benazepril
Amturnide **E**
anastrozole
Antara
Apidra
Aptivus
Arcapta Neohaler
Arimidex **E**
Arixtra
Aromasin
Asmanex Twisthaler
Astagraf XL **E**
Atacand
Atacand HCT
Atelvia **E**
atenolol
atenolol-chlorthalidone
Atripla
atorvastatin
Atrovent HFA
Aubagio
Avalide
Avandamet
Avandaryl
Avandia
Avapro
Avonex
Azasan
azathioprine
Azor **E**

B

benazepril
benazepril-hydrochlorothiazide
Benicar
Benicar HCT
Betaseron
betaxolol*
Bidil
Binosto **E**
bisoprolol
bisoprolol-hydrochlorothiazide
Boniva
Breo Ellipta
Brilinta
Brovana
budesonide
bumetanide
Bydureon
Byetta
Bystolic

C

Calan
Calan SR
calcitonin (salmon)
candesartan
candesartan-hydrochlorothiazide
Capoten
Capozide
captopril
captopril-hydrochlorothiazide
Cardene SR
Cardizem
Cardizem CD
Cardizem LA
Cardizem SR
Cardura
Cardura XL
Cartia XT
carvedilol
Catapres
Catapres TTS
Cellcept
chlorothiazide
chlorpromazine
cholestyramine
cholestyramine light
choline fenofibrate **E**
cilostazol
clonidine
clonidine patch
clopidogrel
Clorpress
clozapine
Clozaril
Colestid
colestipol
Combivent
Combivent Respimat
Combivir
Complera
Copaxone
Coreg
Coreg CR **E**
Corgard
Corzide
Coumadin
Covera HS
Cozaar
Crestor
Crixivan
cromolyn
Cycloset
cyclosporine

D

Daliresp
Demadex
Diabeta
Diabetic Meters - Control Solutions
Diabetic test strips
Diabetic Testing - Lancets
didanosine
Didronel
Dilacor XR
Dilt CD
Dilt XR
Diltia XT
diltiazem
diltiazem ER
Diltzac ER
Diovan
Diovan HCT **E**
dipyridamole
Diuril
doxazosin
Duetact
Dulera
Duoneb
Dutoprol
Dyazide
Dynacirc CR
Dyrenium

E

Edarbi
Edarbyclor
Edecrin
Edurant
Effient
Eliquis
Elixophyllin
Emtriva
enalapril
enalapril-hydrochlorothiazide
enoxaparin
Epaned **E**
Epivir
eplerenone
eprosartan
Epzicom
etidronate
Evista
exemestane
Exforge **E**
Exforge HCT **E**
Extavia **E**

F

Fanapt
Fareston
FazaClo
felodipine ER
Femara **E**
fenofibrate
fenofibrate 48, 145 mg **E**
fenofibrate micronized
fenofibric acid
Fenoglide
Fibricor
Flovent Diskus
Flovent HFA
fluphenazine
fluvastatin
fondaparinux
Foradil
Fortamet
Forteo
Fortical
Fosamax
Fosamax plus D
fosinopril
fosinopril-hydrochlorothiazide
Fragmin
furosemide
Fuzeon

G

Gastrocrom
gemfibrozil
Gengraf
Geodon **E**
Gilenya
glimepiride
glipizide
glipizide ER
glipizide-metformin
Glucophage
Glucophage XR
Glucotrol
Glucotrol XL
Glucovance
Glumetza
glyburide
glyburide micronized
glyburide-metformin
Glynase
Glyset
guanabenz
guanfacine

H

haloperidol
heparin
Humalog
Humalog Mix 50/50
Humalog Mix 75/25
Humulin 50/50
Humulin 70/30
Humulin N
Humulin R
hydralazine
hydrochlorothiazide
Hytrin
Hyzaar

I

ibandronate
Imuran
indapamide
Inderal
Inderal LA
Inderide
Innohep
Innopran XL
Inspra
Insulin Needles/Syringes
Intelence
Invega
Invirase
Invokana
ipratropium
ipratropium/albuterol
irbesartan
irbesartan - hydrochlorothiazide
Isentress
Isoptin SR
isradipine

J

Jantoven
Janumet
Janumet XR
Januvia
Jentadueto
Juxtapid

K

Kaletra
Kazano
Kombiglyze XR
Kynamro

E May be excluded from coverage. *Coverage is provided for oral formulations.

Alphabetical Listing – Expanded List

L

labetalol
lamivudine
lamivudine-zidovudine
Lantus
Lasix
Latuda
Lescol
Lescol XL
letrozole
levalbuterol nebulized solution **E**
Levemir
Lexiva
Lipitor **E**
Lipofen
Liptruzet **E**
lisinopril
lisinopril-hydrochlorothiazide
Livalo
Lopid
Lopressor
Lopressor HCT
losartan
losartan-hydrochlorothiazide
Lotensin
Lotensin HCT
Lotrel
lovastatin
Lovaza
Lovenox
loxapine
Lufyllin

M

Mavik
Maxzide
Metaglip
metaproterenol
metformin
metformin ER
methyclothiazide
methyldopa
methyldopa-hydrochlorothiazide
metolazone
metoprolol succinate
metoprolol tartrate
metoprolol-hydrochlorothiazide
Mevacor
Miacalcin
Micardis
Micardis HCT
Microzide
Midamor
Minipress
minoxidil
Moban
moexipril
moexipril-hydrochlorothiazide
montelukast
mycophenolate
Myfortic

N

nadolol
nadolol-bendroflumethazide
nateglinide
Navane
Neoral
nevirapine
Nesina
Nexiclon XR **E**
Niacor
Niaspan
nicardipine
nifedipine
nifedipine ER
nimodipine
nisoldipine
Norvasc
Norvir
Novolin 70/30
Novolin N
Novolin R
Novolog
Novolog Mix 70/30

O

olanzapine
Onglyza
Oseni

P

Pediatric Flouride Preparations
Perforomist
perindopril
perphenazine
Persantine
pioglitazone
pioglitazone-glimepiride
pioglitazone-metformin
pindolol
Plavix **E**
Pletal
Pradaxa
PrandiMet
Prandin
Pravachol
pravastatin
prazosin
Precose
Prenatal Vitamins
Prevalite
Prezista
Prinivil
Prinzide
Proair HFA
Procardia
Procardia XL
Prograf
propranolol
propranolol-hydrochlorothiazide
Proventil HFA
Pulmicort
Pulmicort Flexhaler

Q

Questran
Questran Light
quetiapine
quinapril
quinapril-hydrochlorothiazide
Quinaretic
QVAR

R

ramipril
Rapamune
Rebif
repaglinide
Rescriptor
reserpine
Retrovir
Reyataz
Riomet
Risperdal **E**
risperidone

S

Sandimmune
Saphris
Sectral
Selzentry
Serevent Diskus
Seroquel **E**
Seroquel XR
Simcor
simvastatin
Singulair **E**
Soltamox **E**
Spiriva
spironolactone
spironolactone-hydrochlorothiazide
Starlix
stavudine
Stribild
Sular
Sustiva
Symbicort
Symlin

T

tacrolimus
tamoxifen
Tarka
Taztia XT
Tecfidera
Tekamlo **E**
Tekturna
Tekturna HCT
Tenex
Tenoretic
Tenormin
terazosin
terbutaline
Teveten
Teveten HCT
Thalitone
Theo-24
Theochron
theophylline
theophylline/guaifenesin
thioridazine
thiothixene
Tiazac
ticlopidine
timolol*
Tivicay
tolbutamide
Toprol XL
torsemide
Tradjenta
Trandate
trandolapril
trandolapril-verapamil
triamterene-hydrochlorothiazide
Tribenzor **E**
Tricor **E**
trifluoperazine
Triglide
Trilipix **E**
Trizivir
Truvada
Tudorza Pressair
Twynsta **E**

U

Uniretic
Univasc

V

valsartan-hydrochlorothiazide
Vascepa
Vaseretic
Vasotec
Ventolin HFA
verapamil
verapamil ER
Verelan
Verelan PM
Victoza
Videx
Videx EC
Viracept
Viramune
Viramune XR
Viread
VoSpire ER
Vytorin

W

warfarin
Welchol

X

Xarelto
Xopenex HFA
Xopenex nebulized solution **E**

Z

zafirlukast
Zaroxolyn
Zebeta
Zerit
Zestoretic
Zestril
Zetia
Ziac
Ziagen
zidovudine
ziprasidone
Zocor
Zortress
Zyflo
Zyflo CR
Zyprexa **E**

E May be excluded from coverage. *Coverage is provided for oral formulations.

Listing by Therapeutic Category – Expanded List

Anti-Infectives - HIV/AIDS
abacavir
Aptivus
Atripla
Combivir
Complera
Crixivan
didanosine
Edurant
Emtriva
Epivir
Epzicom
Fuzeon
Intelence
Invirase
Isentress
Kaletra
lamivudine
lamivudine-zidovudine
Lexiva
nevirapine
Norvir
Prezista
Rescriptor
Retrovir
Reyataz
Selzentry
stavudine
Stribild
Sustiva
Tivicay
Trizivir
Truvada
Videx
Videx EC
Viracept
Viramune
Viramune XR
Viread
Zerit
Ziagen
zidovudine

Breast Cancer Prevention
anastrozole
Arimidex **E**
Aromasin
exemestane
Fareston
Femara **E**
letrozole
Soltamox **E**
tamoxifen

Cardiovascular/Heart Disease - Blood Clot/Platelet Therapy
Aggrenox
Arixtra
Brilinta
cilostazol
clopidogrel
Coumadin
dipyridamole
Effient
Eliquis
enoxaparin
fondaparinux
Fragmin
heparin
Innohep
Jantoven
Lovenox
Persantine
Plavix **E**
Pletal
Pradaxa
ticlopidine
warfarin
Xarelto

Cardiovascular/Heart Disease - High Blood Pressure
Accupril
Accuretic
acebutolol
Aceon
Adalat CC
Afeditab
Aldactazide
Aldactone
Altace
amiloride
amiloride-hydrochlorothiazide
amlodipine
amlodipine-benazepril
Amturnide **E**
Atacand
Atacand HCT
atenolol
atenolol-chlorthalidone
Avalide
Avapro
Azor **E**
benazepril
benazepril-hydrochlorothiazide
Benicar
Benicar HCT
betaxolol*
Bidil
bisoprolol
bisoprolol-hydrochlorothiazide
bumetanide
Bystolic
Calan
Calan SR
candesartan
candesartan-hydrochlorothiazide
Capoten
Capozide
captopril
captopril-hydrochlorothiazide
Cardene SR
Cardizem
Cardizem CD
Cardizem LA
Cardizem SR
Cardura
Cardura XL
Cartia XT
carvedilol
Catapres
Catapres TTS
chlorothiazide
clonidine
clonidine patch
Clorpress
Coreg
Coreg CR **E**
Corgard
Corzide
Covera HS
Cozaar
Demadex

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Listing by Therapeutic Category – Expanded List

Dilacor XR
Dilt CD
Dilt XR
Diltia XT
diltiazem
diltiazem ER
Diltzac ER
Diovan
Diovan HCT **E**
Diuril
doxazosin
Dutoprol
Dyazide
Dynacirc CR
Dyrenium
Edarbi
Edarbyclor
Edecrin
enalapril
enalapril-hydrochlorothiazide
Epaned **E**
eplerenone
eprosartan
Exforge **E**
Exforge HCT **E**
felodipine ER
fosinopril
fosinopril-hydrochlorothiazide
furosemide
guanabenz
guanfacine
hydralazine
hydrochlorothiazide
Hytrin
Hyzaar
indapamide
Inderal
Inderal LA
Inderide
Innopran XL
Inspra
irbesartan
irbesartan - hydrochlorothiazide
Isoptin SR
isradipine
labetalol
Lasix
lisinopril
lisinopril-hydrochlorothiazide
Lopressor
Lopressor HCT
losartan
losartan-hydrochlorothiazide
Lotensin
Lotensin HCT
Lotrel
Mavik
Maxzide
methyclothiazide
methyldopa
methyldopa-hydrochlorothiazide
metolazone
metoprolol succinate
metoprolol tartrate
metoprolol-hydrochlorothiazide
Micardis
Micardis HCT
Microzide
Midamor
Minipress
minoxidil
moexipril
moexipril-hydrochlorothiazide
nadolol
nadolol-bendroflumethazide
Nexiclon XR **E**
nicardipine
nifedipine
nifedipine ER
nimodipine
nisoldipine
Norvasc
perindopril
pindolol
prazosin
Prinivil
Prinzide
Procardia
Procardia XL
propranolol
propranolol-hydrochlorothiazide
quinapril
quinapril-hydrochlorothiazide
Quinaretic
ramipril
reserpine
Sectral
spironolactone
spironolactone-hydrochlorothiazide
Sular
Tarka
Taztia XT
Tekamlo **E**
Tekturna
Tekturna HCT
Tenex
Tenoretic
Tenormin
terazosin
Teveten
Teveten HCT
Thalitone
Tiazac
timolol*
Toprol XL
torsemide
Trandate
trandolapril
trandolapril-verapamil
triamterene-hydrochlorothiazide
Tribenzor **E**
Twynsta **E**
Uniretic
Univasc
valsartan-hydrochlorothiazide
Valturna **E**
Vaseretic
Vasotec
verapamil
verapamil ER
Verelan
Verelan PM
Zaroxolyn
Zebeta
Zestoretic
Zestril
Ziac

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Listing by Therapeutic Category – Expanded List

Cardiovascular/Heart Disease - High Cholesterol

Advicor
Altoprev **E**
Antara
atorvastatin
cholestyramine
cholestyramine light
choline fenofibrate **E**
Colestid
colestipol
Crestor
fenofibrate
fenofibrate 48, 145 mg **E**
fenofibrate micronized
fenofibric acid
Fenoglide
Fibricor
fluvastatin
gemfibrozil
Juxtapid
Kynamro
Lescol
Lescol XL
Lipitor **E**
Lipofen
Liptruzet **E**
Livalo
Lopid
lovastatin
Lovaza
Mevacor
Niacor
Niaspan
Pravachol
pravastatin
Prevalite
Questran
Questran Light
Simcor
simvastatin
Tricor **E**
Triglide
Trilipix **E**
Vascepa
Vytorin
Welchol
Zetia
Zocor

Central Nervous System - Multiple Sclerosis

Aubagio
Avonex
Betaseron
Copaxone
Extavia **E**
Gilenya
Rebif
Tecfidera

Central Nervous System - Psychosis

Abilify
chlorpromazine
clozapine
Clozaril
Fanapt
FazaClo
fluphenazine
Geodon **E**
haloperidol
Invega
Latuda
loxapine
Moban
Navane
olanzapine
perphenazine
quetiapine
Risperdal **E**
risperidone
Saphris
Seroquel **E**
Seroquel XR
thioridazine
thiothixene
trifluoperazine
ziprasidone
Zyprexa **E**

Endocrine/Diabetes - Diabetic Supplies

Diabetic Meters - Control Solutions
Diabetic test strips
Diabetic Testing - Lancets
Insulin Needles/Syringes

Endocrine/Diabetes - Insulin

Apidra
Humalog
Humalog Mix 50/50
Humalog Mix 75/25
Humulin 50/50
Humulin 70/30
Humulin N
Humulin R
Lantus
Levemir
Novolin 70/30
Novolin N
Novolin R
Novolog
Novolog Mix 70/30

Endocrine/Diabetes - Non-Insulin

acarbose
ACTOplus met
ACTOplus met XR
Actos **E**
Amaryl
Avandamet
Avandaryl
Avandia
Bydureon
Byetta
Cycloset
Diabeta
Duetact
Fortamet
glimepiride
glipizide
glipizide ER
glipizide-metformin
Glucophage
Glucophage XR
Glucotrol
Glucotrol XL
Glucovance
Glumetza
glyburide
glyburide micronized
glyburide-metformin
Glynase
Glyset
Invokana
Janumet

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Listing by Therapeutic Category – Expanded List

Janumet XR
Januvia
Jentadueto
Kazano
Kombiglyze XR
Metaglip
metformin
metformin ER
nateglinide
Nesina
Onglyza
Oseni
pioglitazone
pioglitazone-glimepiride
pioglitazone-metformin
PrandiMet
Prandin
Precose
repaglinide
Riomet
Starlix
Symlin
tolbutamide
Tradjenta
Victoza

Immunosuppressant - Organ Rejection

Astagraf XL **E**
Azasan
azathioprine
Cellcept
cyclosporine
Gengraf
Imuran
mycophenolate
Myfortic
Neoral
Prograf
Rapamune
Sandimmune
tacrolimus
Zortress

Musculoskeletal - Osteoporosis

Actonel
alendronate
Atelvia **E**
Binosto **E**
Boniva
calcitonin (salmon)
Didronel
etidronate
Evista
Forteo
Fortical
Fosamax
Fosamax plus D
ibandronate
Miacalcin

Respiratory - Asthma/COPD

Accolate
Accuneb
Advair Diskus
Advair HFA
Aerobid
albuterol nebulized solution
albuterol oral tablet
Alvesco
aminophylline
Arcapta Neohaler
Asmanex Twisthaler
Atrovent HFA
Breo Ellipta
Brovana
budesonide
Combivent
Combivent Respimat
cromolyn
Daliresp
Dulera
Duoneb
Elixophyllin
Flovent Diskus
Flovent HFA
Foradil
ipratropium
ipratropium/albuterol
levalbuterol nebulized solution **E**
Lufyllin
metaproterenol
montelukast
Perforomist
Proair HFA
Proventil HFA
Pulmicort
Pulmicort Flexhaler
QVAR
Serevent Diskus
Singulair **E**
Spiriva
Symbicort
terbutaline
Theo-24
Theochron
theophylline
theophylline/guaifenesin
Tudorza Pressair
Ventolin HFA
VoSpire ER
Xopenex HFA
Xopenex nebulized solution **E**
zafirlukast
Zyflo
Zyflo CR

Vitamins

Pediatric Flouride Preparations (for example: Florvite, Poly-Vi-Flor, Tri-Vi-Flor) - Brand Name and Generic Products
Prenatal Vitamins (for example: Citranatal Assure, Prenate DHA, Stuartnatal) - Brand Name and Generic Products

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Listing by Therapeutic Category – Expanded List

If you have pharmacy benefit coverage with UnitedHealthcare, you may learn more about your benefit by visiting **myuhc.com**® or by calling the toll-free member phone number on the back of your ID card. If you are not currently enrolled with UnitedHealthcare for pharmacy benefit coverage, you may access **myuhc.com** for additional information during your open enrollment period or you may contact your employer or health plan for additional information.

Medications are categorized by common therapeutic conditions in this reference guide for ease of reference only. These categories do not determine coverage for the medication for your condition. Your benefit plan determines how these medications may be covered for you.

Where differences are noted between this reference guide and your benefit plan documents, the benefit plan documents will govern.

E May be excluded from coverage.

*Coverage is provided for oral formulations.

Generic medications are noted in lower case lettering.

Clinical programs such as Notification/Prior Authorization, Step Therapy and Supply Limits may apply to listed medications based off your benefit plan.

This list is intended as a reference and may not be all-inclusive. Brand or generic availability may not be current due to changes in the market. The list will be updated annually.

For the most current PDL updates, visit **myuhc.com** or call toll-free member phone number on the back of your health plan ID card.

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