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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COMMUNITY COLLEGE

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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. Eligibility of coverage is always on the 1st or 16th of the month following one month of employment (approximately 30 days).

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/benefits/index.shtml.

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)

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:**<br>Contact UHC first to verify benefits and eligibility or to resolve claim questions.<br><br>**UnitedHealthcare Plan # 708233**<br>Phone: 866-314-0335<br>Website: www.myuhc.com | **PPO/CORE/Tiered Core Plan:**<br>Contact UHC first to verify benefits and eligibility or to resolve claim questions.<br><br>**UnitedHealthcare Plan # 708233**<br>Phone: 866-633-2446<br>Website: www.myuhc.com |
| **HSA Contributions:**<br>**Monessa Bradford**<br>614-287-2107 | **Wellness Initiative – Health Rewards:**<br>Wellness Coordinator:<br><br>**Nichole Bowman-Glover**<br>Phone: 614-287-3989 |
| **Enrollment/Eligibility Advocate:**<br>Changes or Modifications<br>**Monessa Bradford**<br>614-287-2107 | **Interpreting Requests for Hearing Impaired:**<br>**Monessa Bradford**<br>614-287-2107 |
| **COBRA:**<br>**UnitedHealthcare Benefit Services**<br>**OptumHealth Financial Services**<br><br>Phone: 1-866-747-0048 | **Life Insurance Questions:**<br>**MetLife**<br>Waiver of Premium Customer Service: 1-800-300-4296<br>Life Conversions Customer Service: 1-877-275-6387<br>Life Claims Customer Service: 800-638-6420 prompt 2 |
| **Retirement – STRS, SERS, 457, and 403b :**<br>**FSA Contributions:**<br>Program Coordinator of Retirement Benefits:<br>**Twila Wiley**<br>614-287-2422<br>**TASC Id# 4901-4755-9523**<br>800-422-4661 | |
| **Vision Plan:**<br>**VSP Plan #30008366**<br>Phone: 800-877-7195<br>www.Vsp.com | **Dental Plan:**<br>**Delta Dental Plan #0007414**<br>Phone: 800-524-0149<br>www.Deltadentaloh.com |
| **EAP:**<br>**Matrix**<br>Phone: 614-475-9500 or 800-886-1171<br>www.matrixpsych.com | |
| **Fee Waiver**<br><br>**Darrylene (Candy) Mason**<br>614-287-2406 | **Tuition Reimbursement**<br><br>**Carmelita Boyer**<br>614-287-2407 |

COLUMBUS STATE COMMUNITY COLLEGE

# Benefit Checklist

| Coverage Type | Forms Included | |
|---|---|---|
| ***Pre or Post Tax*** | | |
| **Section 125 Cafeteria Plan**<br>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**<br>Health Care/Dependent Care | ☐ **Yes** | ☐ **No** |
| ***Life and AD&D Form*** | | |
| **Group Life/AD&D Insurance**<br>MetLife | ☐ **Yes** | ☐ **No** |
| **Long Term Disability Insurance**<br>MetLife | ☐ **Yes** | ☐ **No** |
| **Additional Life/AD&D**<br>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 _____

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☐ **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**<br>☐ HDHP/HSA Plan<br>☐EE only ☐Family Coverage | ☐**Dental Plan** | ☐ Vision |
| ☐ Birth | ☐ Other *include legal document | ☐ Tiered Core Plan<br>☐ EEonly ☐EE + spouse<br>☐EE + 1 or 2 Children<br>☐ Family coverage | ☐EE only<br>☐ Family coverage | ☐EE only<br>☐ Family coverage |
| | | ☐ Waive/Decline (See # 7) | ☐ Waive/Decline (See # 7) | ☐ Waive/Decline (See # 7) |

| **4. Employee Information** | | | | | | |
|---|---|---|---|---|---|---|
| Last name | First name | Date of birth | Age | Sex<br>☐ M<br>☐ F | Social Security # | ☐ Single<br>☐Married<br>☐Divorced<br>☐Widowed |
| Home Address | | City | State | Zip code | County | |
| Home telephone | | e-mail address | | | Other Coverage Indicator:<br>☐Yes<br>☐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 re

| 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 | Last name | First name, | MI |
|---|---|---|---|

| ☐ Cancel | | | | | |
|---|---|---|---|---|---|
| Date of Birth<br>/ / | Sex<br>☐ M<br>☐ F | Social Security # | Relationship to employee<br>☐Other ☐Step Child<br>☐Child ☐Partner's Child | Reason for change | Other Coverage Indicator:<br>☐Yes<br>☐No |
| If the dependent's address is different than the employee, please provide full address. | | | | | |

| | | | | | |
|---|---|---|---|---|---|
| **(4)** ☐Add<br>☐ Cancel | | Last name | | First name, | MI |
| Date of Birth<br>/ / | Sex<br>☐ M<br>☐ F | Social Security # | Relationship to employee<br>☐Other ☐Step Child<br>☐Child ☐Partner's child | Reason for change | Other Coverage Indicator:<br>☐Yes<br>☐No |
| If the dependent's address is different than the employee, please provide full address. | | | | | |
| **(5)** ☐Add<br>☐ Cancel | | Last name | | First name, | MI |
| Date of Birth<br>/ / | Sex<br>☐ M<br>☐ F | Social Security # | Relationship to employee<br>☐Other ☐Step Child<br>☐Child ☐Partner's child | Reason for change | Other Coverage Indicator:<br>☐Yes<br>☐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:<br>☐Myself<br>☐Spouse/Partner<br>☐Dependent Children<br>☐Myself and all dependents | I Decline coverage due to the existence of other coverage:<br>☐ Spouse/Partner Employer's Plan ☐VA Eligibility<br>☐ Individual Plan ☐ Medicare/Medicaid<br>☐No other coverage at this time |
| Name of Employer where the above is covered by insurance (if applicable)<br>_____<br>_____<br>Carrier:<br>☐ 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.<br>(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.<br>(c) I am responsible to timely notify my employer of any change that would make me or any dependent ineligible for benefits.<br>(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.<br>(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.<br>(f) I attest that I have reviewed the Dependent Eligibility Definitions and that the information and documentation I am submitting are true and accurate. | 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.<br><br>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.<br><br>I confirm that the information I have provided on this form is complete and accurate.<br><br>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.<br><br>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. |
| **Employee signature to enroll in selected benefit plans:** | **Date** / / |

# COLUMBUS STATE COMMUNITY COLLEGE
# REQUIRED DEPENDENT VERIFICATION INFORMATION

| Dependents | Eligibility Definition | Required Documentation |
|---|---|---|
| **SPOUSE/DOMESTIC PARTNER** | A member of the opposite sex to whom you are legally married.<br><br>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***<br>• Photocopy of marriage certificate if marriage has occurred within one year of eligibility.<br>• For the domestic partner, at least three of the documents described in the Affidavit. |
| **CHILDREN**<br>Eligible dependent children include:<br><br>Natural Children<br>Step children<br>Legally Adopted Children<br>Children placed for adoption<br>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.<br><br>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:<br><br>• 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;<br>• Ordered to be covered by a Qualified Medical Child Support Order or other court or administrative order.<br><br>Please see additional eligibility for Qualifying Disabled Children | • ***Natural Children:*** Photocopy of birth certificates showing employee's name.<br>• ***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.<br>• ***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.<br>• ***Children of the domestic partner***: Photocopy of birth certificates showing the partner's name.<br>• 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**

**This document is required when the SP/DP is covered under the College's Medical Plan**

A working SP/DP surcharge will be added to your premium if your SP/DP is covered under the College's medical plan and your SP/DP is eligible for coverage through his/her employer but did not to enroll in their employer coverage. The surcharge does not apply if both the EE and SP/DP are employed by Columbus State.

____My SP/DP is enrolled in The College's medical plan

____My SP/DP is not employed

____My SP/DP is employed

____ My SP/DP is **not offered** medical coverage through his/her employer

____ My SP/DP **is offered** medical coverage through his/her employer

____ My SP/DP **has enrolled** in his/her medical coverage

____ My SP/DP **did not enroll** in his/her medical coverage

**REQUIRED INFORMATION**

**SP/DP Name:** _____
**SP/DP's Employer:** _____
**Address:** _____
**Phone Number:** _____
**SP/DP's Medical Coverage Plan Name:** _____
**SP/DP's Group #**_____
**If the SP/DP has enrolled in their employer plan, a copy of the SP/DP's Medical ID must accompany this affidavit.**

____My **SP/DP is enrolled in The College's medical plan** and **my SP/DP has medical coverage available through his/her employer** and **has not enrolled in their** medical plan. (**I understand the $50/$66.67 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 Resources Department and your SP/DP is enrolled in the College's coverage, you will be charged the surcharge until this form is received. If your SP/DP **obtains or loses** health coverage through their employer, you are required to notify the College's Human Resources Department within 31 days of such change. Failure to provide notification to Human Resources 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 the status of my SP/DP's medical coverage changes, it is my responsibility to notify the Human Resources 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 medical coverage information shall be considered grounds for disciplinary action.**

_____ Name (Please Print)

_____ Name (Signature)

_____ Employee #

_____ Date

FlexSystem™

TASC®

# Limited Service HSA Participant Reference Guide

## Health Savings Accounts

Health Savings Accounts (HSA) are an excellent way to help fund medical expenses. Established under 2003 Medicare legislation, the tax-favored treatment of HSAs authorizes individuals and employers alike to use HSAs in conjunction with High Deductible Health (insurance) Plans (HDHPs). HSA participants deposit funds into the account tax-free via salary reductions, and use the funds to pay for qualified medical expenses. Held in a custodial account, the funds are withdrawn when a qualified medical expense is incurred. At Plan Year end, unused balances are retained in the account and—depending on Plan design—may be carried over to subsequent Plan Years. In addition, funds in the accounts belong to the individual and are portable from job to job.

## Eligibility

To be eligible for an individual medical HSA, a Participant must be enrolled in a qualifying deductible health plan or be applying for one in conjunction with the HSA, and must not be covered by another health insurance plan (other than a plan providing certain limited types of coverage, such as accidental and scheduled benefits plans).

## High Deductible Health Plan

In a High Deductible Health Plan, the annual deductible must be at least $1,300 for individuals and $2,600 for families (2015 limits). Furthermore, limits are imposed regarding total out-of-pocket expenses allowed under the health insurance plan. All of these limitations are subject to annual cost of living adjustments.

## Contributions and Their Tax Deductibility

Contributions to an HSA are tax deductible up to certain limits. For 2015, the maximum annual contribution limit is $3,350 for individual and $6,650 for family coverage. Participants in a High Deductible policy that begins any time after January may contribute up to the annual maximum, regardless of the number of months in the year in which they are eligible. Contributions to an HSA through FlexSystem are not subject to Federal and State (some states may vary) income tax or FICA. Made via payroll deduction, the contributions are taken on a pre-tax basis and transferred via FlexSystem HSA services to the Participant's HSA account, as authorized by the Participant.

## Withdrawals

The money in the HSA accumulates on a tax-deferred basis. Withdrawals for qualified medical expenses are not taxable. Withdrawals prior to age 65 for reasons other than qualified medical expenses are taxable and subject to a 20 percent penalty. Upon death, disability, age 65, or upon Medicare eligibility, funds can be withdrawn for non-medical reasons without penalty, but the distributions will be subject to income taxes.

## Participant Responsibilities

Per tax deductibility requirements, Participants should ensure (a) that their contributions to the HSA do not exceed the maximum limits, and (b) that withdrawals are for qualified medical expenses only. These expenses are defined in Section 213(d) of the Internal Revenue Code.

## Disbursements

Participants may request reimbursement any time a qualified expense has been incurred. Distributions will be made at the Participant's (Depositor) direction consistent with the direction provided by the Custodian of the Participant's HSA. The Participant (Depositor) acknowledges that any withdrawals that are not qualified medical expenses are taxable and subject to penalty taxes in certain circumstances. In the event of death, the account will be distributed to the depositor's beneficiary. The Custodian may resign at any time upon 60 days notice to the Participants (Depositor) and may distribute the then balance to the Participant (Depositor) in full satisfaction of its obligation.

Sufficient funds must be present in the account for an amount equal to the expense to be withdrawn or paid.

## Interest Bearing Accounts

Interest or other earnings on the balance of funds in the HSA are specific to the Custodian.

## Administrative Fees

A minimum deposit may be required by the Custodian to open and maintain an HSA. Account and service fees pursuant to schedule are established by the Custodian.

## Account Communication

The Participant (Depositor) agrees to provide the Custodian with information necessary for the Custodian to prepare any reports required by law. The Custodian agrees to submit reports to the Internal Revenue Service and the Participant (Depositor) as prescribed by the Internal Revenue Service. Any other account communication is specified by the Custodian.

**FlexSystem HSA Operations**
Enrollees complete and return HSA Payroll Deduction Election and Direct Deposit Form to the employer's designated position. HSA payroll deduction election amounts and changes therein are to be communicated to FlexSystem. The employer deducts the elected amount; FlexSystem places the funds in the Participant's custodial account until reimbursement is requested.

The Depositor whose name appears on the HSA application is establishing a Health Savings Account pursuant to Internal Revenue Code Section 223 and the Custodian. The Custodian may accept cash contributions on behalf of the Depositor. Contributions may not exceed annual dollar limits permitted by law. The Depositor's interest in the balance in the custodial account is non-forfeitable. The custodial account shall be invested for one sole purpose: that of the Custodian to make distributions on behalf of the Depositor. Participants must be establishing or have established a High Deductible Health Plan (HDHP) in order to be eligible for a HSA custodial account.

**FlexSystem Health Savings Account Coordination with a FlexSystem Health Flexible Spending Account**
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 otherwise by the High Deductible Health Plan itself. For example, if the High Deductible Health Plan does not cover dental expenses, the health FSA may be established to reimburse dental expenses only. If the High Deductible Health Plan does not cover prescription costs, the health FSA may be structure to reimburse prescription expenses only.

**FlexSystem Health Savings Account effect on Social Security benefits**
Reduction of Participant Social Security benefits is minimal and is offset by the tax savings and lower health care costs available under the FlexSystem Health Savings Account. To compensate for this minimal reduction, Participants may increase retirement plan funding.

**Call FlexSystem at 1-800-422-4661 and ask a FlexSystem Client Services Representative for assistance with the enrollment forms.**

TASC • 2302 International Lane • Madison, WI 53704-3140 • 1-800-422-4661 • Fax: 608-245-3623 • www.tasconline.com

FlexSystem™

TASC®

# Limited Service Health Savings Account (HSA) Enrollment, Payroll Deduction Election, and Direct Deposit Form

See page 2 for instructions on completing this form. **Return the completed and signed form to your employer. Retain a copy for your files.**

## Enrollment

Client ID Number 4700-9284-3657 Employer Name Columbus State Community College

Participant ID 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 (TASC) to act on my behalf to direct the designated monies into the Health Savings Account established in my name. I request the following amount(s) to be deducted pre-tax from my payroll:

Participant's Plan Effective Date _____ Date of First Payroll Contribution _____

| | Annual Benefit Amount * | | # of Payrolls | | Per Payroll Amount |
|---|---|---|---|---|---|
| Health Savings Account | $_____ | (divided by) | _____ | = | $ _____ |
| Employer Contribution | $_____ | (divided by) | _____ | = | $ _____ |

* See the HSA Participant Reference Guide for more information.

I hereby authorize Total Administrative Services Corporation, hereinafter called TASC, to facilitate credit entries to the account indicated below and the financial institution named below, hereinafter called FINANCIAL INSTITUTION, and 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.

## HSA Account Information

Financial Institution Name _____ Branch _____

Address _____ City _____ State _____ Zip Code _____

Account Routing Number _____ Account Number _____

Account Type: ❍ Checking ❍ Savings ❍ Other _____

## Authorization

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 in 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 (a) the Health Savings Account deduction will be in effect until I cancel or terminate my participation, (b) annual renewal of the HSA is unnecessary, and (c) I may make changes at any time to my HSA contribution. 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 Client ID Number and Company Name. Make sure to have this information available when calling for enrollment assistance.

**Section 2 – Health Savings Account Information:** Enter information regarding your selected HSA custodial account in the space indicated. The Account Routing Number, the Type of Account, and the Account Number are all required to set up your HSA account. 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 and date the form. Retain a copy for your file and return the completed original to your employer.

## Frequently Asked Questions

**1. What does FlexSystem Health Savings Accounts (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 $1,250 for single coverage and $2,500 for family coverage (2014 limits).

**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 (some states may vary), federal or SS tax.

**3. How does it work?** The tax-free payroll contributions are deposited into a selected bank's custodial account. When a qualified expense is incurred, you simply request that the custodial account pay the expense.

**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 (FSA). 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 itself. For example, if the High Deductible Health Plan does not cover dental expenses, the health FSA may be established to reimburse dental expenses only. If the High Deductible Health Plan does not cover prescription costs, the health FSA may be structured to reimburse prescription expenses only.

**5. Is there any cost to me to maintain an HSA?** No.

**6. What are qualified medical expenses?** These include expenses dental care, prescriptions, eyeglasses, and out-of-pocket medical expenses not covered by insurance. Conversely, 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 reimbursable only if accompanied by a prescription from your physician. Below are some examples of health related expenses.

**Items that require a prescription 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 | Hemmorrhoidal Medications | Sleep Aids and Sedatives |
| Anti-Gas and Diarrheals | Cough, Cold and Flu | Laxatives | Stomach Remedies |

**Items that need no physician authorization include the following:**

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

**7. How does a Health Savings Account affect Social Security benefits?** Reduction of your Social Security benefits is minimal and is offset by the tax savings and lower health care costs available under FlexSystem. To compensate for this minimal reduction, you may increase your retirement plan funding.

**8. 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 your 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.

TASC • 2302 International Lane • Madison, WI 53704-3140 • 1-800-422-4661 • Fax: 608-245-3623 • www.tasconline.com

# 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<br>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.

**GEF02-1**
**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<br>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.

**GEF09-1**
**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 Compensation Enrollment Form

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

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

Make sure to sign, date, and complete each line on the enrollment form. Please enter zero (0) where no amount is being deducted. **Return the completed and signed form to your employer**. For enrollment assistance, call toll-free 800-422-4661. Have your enrollment form, Client ID, and company name ready. **Please Print.**

Participant Last Name_____First Name_____Middle Initial_____

Participant TASC ID (if known)_____Participant Email Address* _____

Participant Home Phone Number* _____ Participant Mobile Phone Number* _____

Participant Address _____

City _____State _____Zip _____

Participant's Plan Effective Date _____Date of First Payroll _____

Participant's Cougar Id# _____

*Required to access your account online or via your mobile phone, or to receive personal account notifications. Information is confidential and is not used for marketing purposes.

## Election Amounts

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

| I request the following amount(s) to be deducted pre-tax: | **Maximum Employee Salary Reduction** | **Employee Annual Salary Reduction** |
|---|---|---|
| **Medical (Out-of-Pocket) Expenses** | $ 2,550.00 | $ _____ |
| **Dependent Care Expenses(Daycare)** | $ 5,000.00 | $ _____ |
| **Non-Employer Sponsored** | No Maximum | $ _____ |
| **Transit Expenses** | $ 1,560.00 | $ _____ |

## TASC Card

**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 per year toward deductible and co-insurance portions of health insurance, dental expenses, orthodontic expenses, eye care, and other miscellaneous healthcare expenses. Per IRS regulations, a Participant may salary reduce the maximum of $2,500 (2014) and $2,550 (2015) per Plan Year (indexed annually for inflation). Your employer may have a Plan Year maximum less than the IRS allowed amount. Review your Summary Plan Description (SPD) or check with your employer for your Plan's maximum amount.

**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:** Pre-tax reimbursement of privately purchased insurance premiums such as health, disability, and cancer insurance. Examples of insurance premiums NOT eligible are employer sponsored group insurance (premiums deducted from your paycheck or your spouse's paycheck), life insurance, long-term care insurance, and premiums for coverage under the federal exchange"Marketplace" program. Please note, when disability premiums are pre-taxed, the benefits received are taxable.

**Transit Expenses:**Amount incurred to travel to and from work on mass transit facilities or commuter highway vehicles. Examples of eligible expenses are vouchers, farecards, or tokens for a bus, train, ferry, subway, or vanpool. Monthly limits apply.

## 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 eligible OTC health related expenses:

**OTC items that require a prescription or Prescription Order Form:** Acid Controllers, Allergy and Sinus, Antibiotic Products, Cough,Cold and Flu, Digestive Aids, Pain Relief, Respiratory Treatments, Sedatives, and Stomach Remedies.

### 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.

**OTC items that are eligible and need no physician authorization:**Bandages, Blood Pressure Kits, Contact Lenses, Contact Lens Solution, Diabetes Testing Supplies, Durable Medical Equipment, Hearing Aid Batteries, Heating Pads, Insulin, Nebulizers, Thermometers,Walkers and Wheelchairs.

**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 may be changed only if there is a change in family or employment status. See the Change of Elections Form for more detail.

**8. What is the Use-or-Lose Rule?**To avoid an account balance at year-end, be conservative when making elections. Any funds left unused at the end of the Plan Year are forfeited, unless your employer offers a Carryover (for Medical Out-of-Pocket Expenses Benefit only).

**9. What is the Medical (Out-of-Pocket) Expenses Carryover?**An employer may allow Participants in the Medical (Out-of-Pocket) Expenses Benefit to carryover to next year's Medical Expense Benefit a portion of their unused balance. The Carryover amount applies to the following year's benefit after close of the prior Plan Year Runout, at which time it may be used to reimburse expenses incurred in the new Plan Year. While the IRS Carryover maximum is $500, your employer may establish a lower amount. Refer to your Summary Plan Description for details specific to your Plan.

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

# Medical Plan Summary- Tiered Core/PPO

| **Benefit** | **In Network** |
|---|---|
| Deductible-Single/EE+ 1 or 2 Child(ren)/Family | $750/$1,500/$2250 |
| Coinsurance | 70%/30% |
| Out of Pocket- EE/EE+ 1/ EE plus 2 or more | $4,500/$9,000/$11,250 |
| Office Visit-PCP<br>Office Visit-Specialist<br>Urgent Care<br>Emergency Room | $25 Copay<br>$40 Copay<br>$35 Copay<br>Deductible & Coinsurance |
| Preventive Services | Covered at 100% |
| Preventive Prescriptions (not subject to deductible)<br>Retail | $10 Tier 1/ $40 Tier 2/ $100 Tier 3 |
| Prescriptions- Mail (90 day supply) | $20 Tier 1/ $80 Tier 2/ $200 Tier 3 |

# Medical Plan Summary- Core/PPO

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

# 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 |

## 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 |

# 2015-16 Plan Year Monthly Rates

(Rates may vary based on pay cycle 18/24)

| **Core Plan** | | Without Rewards |
|---|---|---|
| Single | $113.42 | $170.13 |
| Family | $298.29 | $447.44 |
| **HDHP/HSA** | | Without Rewards |
| Single | $100.01 | $150.02 |
| Family | $263.03 | $394.55 |

| **Tiered Core Plan** | | Without Rewards |
|---|---|---|
| EE only | $108.88 | $163.33 |
| EE + spouse | $261.32 | $391.98 |
| EE+ 1 or 2 Child(ren) | $195.99 | $293.98 |
| Family | $286.36 | $429.54 |

| **Dental** | |
|---|---|
| Single | $6.87 |
| Family | $19.69 |

| **Vision** | |
|---|---|
| Single | $3.34 |
| Family | $9.22 |

# 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 |

UnitedHealthcare

# How to Get Started with the Health Rewards Program?

**1.) Make your appointment for your Annual Exam and Biometric Screenings – See Tip Sheet**

**2.) If you haven't registered for access to myuhc.com, please follow the simple steps below to create your pathway to wellness and information.**

Steps below to register.

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

For website assistance, call:

## MYUHC.com assistance at 1.877.844.4999

**Once you have access:**

**Log onto the site any time to explore your opportunities for valuable information!**

## Myuhc.com

**3.) Once you receive your Bio-Metric Screening results, Log-In using your personalized settings that you received during the registration process above to complete your Health Assessment.**

**4.) Log-In to Track Your Points, On the Home Screen, click on either link:**

**Health and Wellness – Upper Right corner**
**Personal Health Record – Upper Right, Over One**

**5.) Log-In to Complete the On-line Coaching**

**6.) Complete any additional steps necessary to accumulate your points.**

## If you have questions regarding your points, please contact UHC technical assistance for the Health Rewards program at 1-866-868-5484!

http://welcometomyuhc.com/healthandwellness/tour/

Note: This packet contains a brief summary of coverage. It does not state all the provisions and limitations of the plan. The terms and provisions of each plan, as outlined in the plan document, will determine coverage and eligibility.

# 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.

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# 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.

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# 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