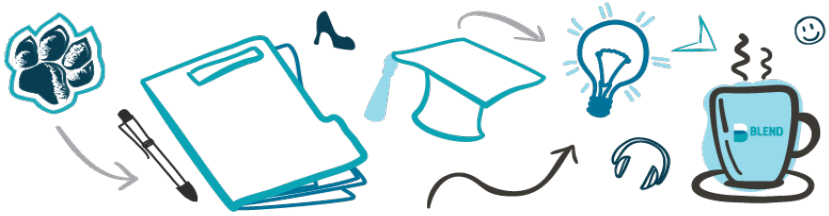
COLUMBUS STATE
COMMUNITY COLLEGE

Benefits Guide

July 1, 2025 - June 30, 2026
Plan Year

You support student success.

HR SUPPORTS *YOUR* SUCCESS.



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Your Benefits at a Glance

Columbus State strives to offer a competitive benefits program to meet your needs and the needs of your family. We are committed to your health and wellbeing and are proud to provide you a comprehensive benefit program as a part of your total rewards package.

MEDICAL & RX

You have the opportunity to choose between two medical plans through UnitedHealthcare:

- **Tiered PPO** (Preferred Provider Organization)
- **HDHP + HSA** (High Deductible Health Plan + Health Savings Account)

Both plans are offered through UnitedHealthcare and utilize the same network pf physicians and pharmacies. Deductibles and out-of-pocket maximums run on a calendar year basis (January through December).

WELLBEING

The wellbeing of our employees and their families is a priority. We provide wellbeing resources to support the eight dimensions of wellbeing.

- Physical
- Emotional
- Financial
- Occupational
- Social
- Intellectual
- Spiritual
- Environmental

Ongoing access to resources, monthly newsletter, workshops, health coaching and education sessions are made available all year long.

DENTAL

Columbus State offers two comprehensive Dental plans through Delta Dental of Ohio:

- **Basic Plan**
- **Buy-Up Plan**

Both plans include a network of providers (PPO) that provide preventive, basic, major, and orthodontia services.

VISION

Columbus State offers vision coverage through Vision Service Plan (VSP). VSP offers a network of providers. Services include an annual eye exam, lenses, and frames or contact lenses.

LONG TERM DISABILITY

Columbus State provides all full-time employees with Long Term Disability benefits and pays the full cost of this coverage.

Enroll today!

Go to cscc.edu/workday to begin the process of enrolling in your benefits.

HEALTH SAVINGS ACCOUNT (HSA)

If you enroll in the HDHP with HSA plan, you may be eligible to open a Health Savings Account. An HSA is a tax-free savings account you can use to pay for eligible healthcare expenses anytime or save for retirement. Columbus State contributes up to $1,000 for single and $2,000 per family.

HEALTH FLEXIBLE SPENDING ACCOUNT (FSA)

You may save money by making pre-tax contributions to a Health FSA to be used for eligible medical expenses incurred by you and your dependents. These accounts are managed by United Healthcare, and expenses can be paid with the FSA debit card or submitted to UHC for reimbursement.

The maximum contribution for 2025 is $3,300. The FSA balance does not rollover at the end of the plan year **(July 1 – June 30)**. Any remaining balance will be forfeited.

LIMITED PURPOSE FLEXIBLE SPENDING ACCOUNT (FSA)

With a Limited Purpose FSA you can save money by making pre-tax contributions which can then be used for eligible dental and vision expenses incurred by you and your dependents. These accounts are managed by United Healthcare, and expenses can be paid with the FSA debit card or submitted to UHC for reimbursement. To be eligible for the Limited Purpose FSA, you must be enrolled in the High Deductible Health Plan (HDHP).

The maximum contribution for 2025 is $3,300. The FSA balance does not rollover at the end of the plan year **(July 1 – June 30)**. Any remaining balance will be forfeited.

DEPENDENT CARE FSA

Employees may save money by making pre-tax contributions to a Dependent Care Spending Account to be used for the care of dependent children under the age of 13 or dependents of any age who are unable to care for themselves.

The maximum contribution for 2025 is $5,000 if married, or $2,500 if single/married and filing separately. The dependent care FSA balance does not roll over at the end of the plan year **(July 1 – June 30).** Any remaining balance will be forfeited.

VOLUNTARY INSURANCE BENEFITS

Columbus State offers Voluntary Life, Accidental Death & Dismemberment, Critical Illness, Hospital Indemnity, Accident, Pet Insurance and Identity Protection Insurance options. Dependent coverage is also available. Employee premiums are paid by direct payroll deduction.

EMPLOYEE ASSISTANCE PROGRAM (EAP)

Columbus State recognizes that seeking counseling services can be difficult and emotional. Confidential counseling sessions are provided virtually and in-person depending on your preference or availability. Full-time employees, spouses/domestic partners, and dependent children are eligible for up to 8 counseling visits annually for each issue. Matrix also offers financial and legal services.

CANCER BRIDGE

This benefit offers personalized access to oncology experts, support, and resources. CancerBridge can help connect you and your family with a comprehensive care team who can answer questions about treatment plans and what to expect.

BASIC LIFE AND ACCIDENTAL DEATH & DISMEMBERMENT (AD&D) INSURANCE

Columbus State provides eligible employees basic life insurance and AD&D equal to two times their annual base earnings, up to a maximum of $500,000.

RETIREMENT BENEFITS

Columbus State supports the efforts of employees to plan for a fulfilling, financially secure retirement. In lieu of Social Security, the College offers retirement programs through our state pension systems:

- **SERS** - School Employees Retirement System
- **STRS** - State Teachers Retirement System
- **ARP**- Alternative Retirement Plan.

Retirement program eligibility is based on your position. Columbus State also offers supplemental, voluntary savings options to allow for additional savings towards retirement.

FEE WAIVERS

The fee waiver program is provided for full-time employees and includes spouses/domestic partners and dependents. A percentage of eligible instructional fees are waived for taking credit courses at CSCC.

OTHER PERKS

Other perks include bookstore discounts, student loan forgiveness, and credit union memberships. Additionally, CSCC offers tuition reimbursement, paid vacation, holidays, and sick pay.

ELIGIBILITY

All employees defined as regular, full-time are eligible for benefits. (All Teamster members falling under this category are excluded from enrolling in CSCC medical, dental, or vision but remain eligible for all other benefits).

Eligible dependents include your legal spouse/domestic partner and dependent children who are covered under the following criteria:

Medical, Vision & Buy-Up Dental	Up to age 26
Basic Dental & Life	Up to age 19 or 25 if full-time student

OPEN ENROLLMENT HIGHLIGHTS

MEDICAL PLAN OPTIONS

We are pleased to offer two medical plan options through UnitedHealthcare. You will have the following options to choose from:

- **Tiered PPO Plan** has a lower deductible and higher out of pocket maximum. This plan includes copays for office visits and prescription drugs. The contributions are a four-tier structure, so employees can choose the option that best meets their needs which allows you to potentially save on contribution cost.
- **HDHP/HSA Plan** has a high deductible and a lower out of pocket maximum. Office visits and prescription drugs are paid at 90% after the deductible. Employees are eligible to open a health savings account to save pre-tax dollars. Columbus State contributes up to $1,000 for single and $2,000 for family coverage.

Both medical plans use the same network of providers through United Healthcare (UHC).

To stretch your healthcare dollars, remember to:

See in-network providers – They've agreed to the plan's negotiated rates. Visit the carrier websites located in the Contacts section of this guide to search for in-network providers near you.

Use mail order pharmacy – This may save time and money.

If you are on the HDHP, **review the preventive drug list** that is not subject to the deductible.

Both plans provide prescription drug and preventive care. And network discounts apply to both plans.

Here's how the plan options compare:

	Tiered PPO Plan	HDHP/HSA Plan
Coverage	**In-Network**	**In-Network**
Annual Deductible		
Employee Only	$750	$2,500
Employee / Family	$750 / $1,500	$3,300 / $6,000 (embedded at $3,300 per family member)
Out-of-Pocket Maximum		
Employee Only	$4,500	$3,000
Employee / Family	$4,500 / $9,000	$4,000 / $8,000 (embedded at $4,000 per family member)
Coinsurance	30%	10%
Office Visit Copay	$25	10% after deductible
Preventive Care	Covered 100%	Covered 100%
Specialist Copay	$40	10% after deductible
Emergency Room Copay	30% after deductible	10% after deductible
Rx (Retail) – Generic Copay	$10	$10 after deductible
Rx (Retail) – Brand Formulary Copay	$40	$30 after deductible
Rx (Retail) – Non-formulary Copay	$100	$80 after deductible

For a complete list of covered services and exclusions, please refer to your "Summary Plan Description."

A CLOSER LOOK AT THE HDHP/HSA

The HDHP with HSA Plan is a high deductible health plan that costs you less from your paycheck, so you keep more of your money. This plan rewards you for taking an active role as a health care consumer and making smart decisions about your health care spending. As a result, you could pay less for your annual medical costs.

Health Savings Account (HSA)

If you enroll in the HDHP Plan, you may be eligible to open an HSA.

An HSA is a **tax-free savings account** you can use to pay for eligible health expenses anytime, even in retirement.

How does an HSA work?

- **Build tax-free savings for health care.** You can make before-tax deductions from your paycheck into your HSA, allowing you to save money by using tax-free dollars to pay for eligible medical, prescription, dental, and vision expenses. The total amount that can be contributed to your HSA each year is limited by the IRS. The following limits apply to 2025:
  - Up to $4,300 for employee-only coverage.
  - Up to $8,550 if you cover dependents.
  - Add $1,000 to these limits if you're age 55 or older.
- **Use it like a bank account.** Pay for eligible medical, prescription, dental, and vision expenses for yourself and your family by swiping your HSA debit card or reimburse yourself for payments you've made (up to the available balance in your account). Keep in mind that you may only access money that is actually in your HSA when making a purchase or withdrawal. There's no need to turn in receipts (but keep them for your records).
- **Keep your money.** Unlike an FSA, the money in your HSA is always yours to keep and can be rolled over from year to year. You can take your unused balance with you when you retire or leave Columbus State.
- **Earn interest and invest for the future.** Once your interest- bearing HSA reaches a minimum balance, you can start an investment account, which offers a variety of no-load mutual funds similar to other investments. You can learn more at **csccbenefits.hrintouch.com.**
- **Never pay taxes.** Contributions are made on a before-tax basis, and your withdrawals will never be taxed when used for eligible expenses. Any interest or earnings on your HSA balance build tax-free, too*

HSA eligibility

- Must be enrolled in a high deductible health plan, like Columbus State's HDHP with HSA Plan.
- Cannot be covered by any other medical plan that is not a qualified HDHP. This includes a spouse's medical coverage unless that coverage is also a qualified HDHP.
- Cannot be enrolled in a traditional health care FSA in 2025. This includes if your spouse has a healthcare FSA at their employer. However, you may be eligible to enroll in a limited purpose FSA.
- Cannot be enrolled in Medicare, including Parts A or B, Medicaid, or Tricare.
- Cannot be claimed as a dependent on another person's tax return.
- Cannot be a veteran who has received treatment, other than preventive care, through the Department of Veterans Affairs within the past three months.

Note: You won't pay federal taxes on HSA contributions. However, you may pay state taxes depending on your residence. Consult your tax advisor to learn more.

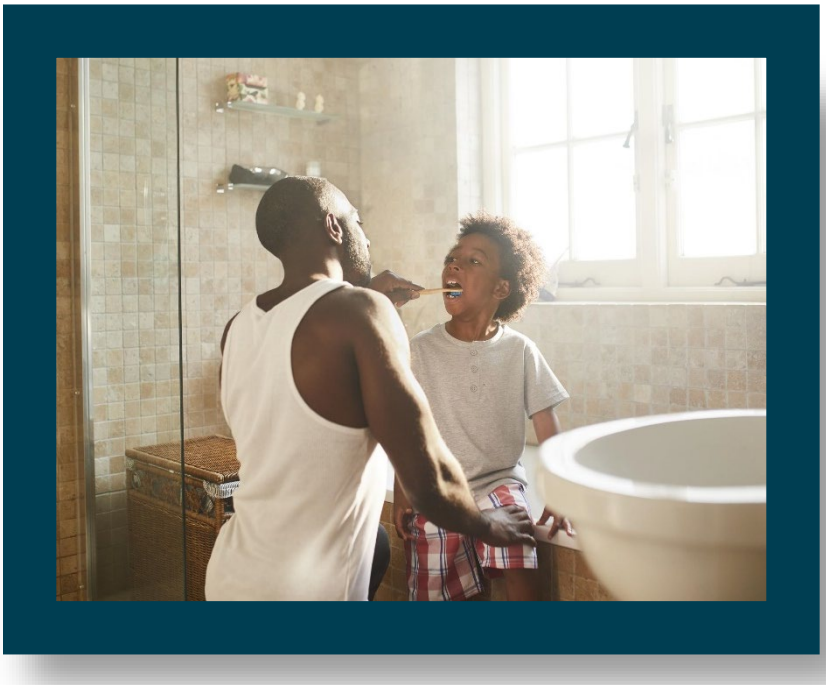
** Money in an HSA grows tax-free and can be withdrawn tax-free if it is used to pay for qualified health care expenses (for a list of eligible expenses, see IRS Publication 502, available at **www.irs.gov**). If money is used for ineligible expenses, you will pay ordinary income tax on the amount withdrawn plus a 20% penalty tax if you withdraw the money for ineligible expenses before age 65. After age 65, withdrawals for ineligible expenses are only subject to ordinary income tax. Please review your state regulations as you may have to pay state taxes depending on your residency.*

DENTAL PLAN OPTIONS

We offer a comprehensive dental plan through Delta Dental of Ohio providing coverage for you and your eligible dependents. Delta Dental of Ohio provides coverage through two networks: Delta Dental PPO and Delta Dental Premier. You receive greater benefit coverage when using a provider in the Delta Dental PPO network. Employees can choose between two plans, allowing for additional coverage for individuals or families who might be experiencing a greater need for dental services.

	Delta Dental PPO Plan			Delta Dental Buy Up Plan		
	PPO Dentist Plan Pays	Premier Dentist Plan Pays	Out-of-Network	PPO Dentist Plan Pays	Premier Dentist Plan Pays	Out-of-Network
Coverage	In-Network	In-Network		In-Network	In-Network	
Annual Deductible (Individual/Family)	$0	$50 / $150	$50 / $150	$0	$75 / $225	$75 / $225
Preventive and Diagnostic Treatment	100%	100%	100%	100%	100%	100%
Basic Treatment	90%	80%	80%	90%	80%	80%
Major Treatment	60%	50%	50%	60%	50%	50%
Annual Maximum Benefit	$1,500	$1,500	$1,500	$2,500	$2,500	$2,500
Orthodontia Lifetime Maximum	$1,000	$1,000	$1,000	$1,500	$1,500	$1,500

When you receive services from an out-of-network dentist, the percentage indicates the portion of Delta Dental's Nonparticipating Dentist fee that will be paid for those services. The Nonparticipating Dentist Fee may be less than what your dentist charges and you are responsible for that difference.



DENTAL PLAN OPTIONS

When you receive services from a Nonparticipating Dentist, the percentage indicates the portion of Delta Dental's Nonparticipating Dentist Fee that will be paid for those services. The Nonparticipating Dentist Fee may be less than what your dentist charges and you are responsible for that difference.

- Oral exams (including evaluations by a specialist) are payable twice per calendar year.
- Prophylaxes (cleanings) are payable twice per calendar year.
- People with specific at-risk health conditions may be eligible for additional prophylaxes (cleanings) or fluoride treatment. The patient should talk with his or her dentist about treatment.
- Fluoride treatments are payable twice per calendar year for people up to age 19.
- Bitewing X-rays are payable once per calendar year. Full mouth X-rays (which include bitewing X-rays) are payable once in any five-year period.
- Sealants are payable once per tooth per lifetime for the first and second permanent molars for people age 14 and under. The surface must be free from decay and restorations.

Porcelain and resin facings on crowns are optional treatment on posterior teeth.

- Implants and implant related services are payable once per tooth in any five-year period.
- Crowns over implants are payable once per tooth in any five-year period. Services related to crowns over implants are payable.
- Composite resin (white) restorations are Covered Services on posterior teeth.

DENTAL BUY-UP EXAMPLE

If you or a dependent child are over the age of 19 and will need braces, selecting the buy-up plan offers coverage for that member. The buy-up plan will cover 50% up to a maximum of $1,500. In addition to higher benefit maximum, it covers eligible dependent children up to age 26. The difference in semi-monthly cost can be found on page 11.

VISION PLAN OPTIONS

Access to vision coverage is provided through VSP. You receive access to greater coverage when using a VSP network provider on items such as progressive lens, lens options and additional hardware discounts beyond the allowances provided. Eligibility up to age 26, unmarried and living in the US, regardless of student status.

Coverage	In-Network	Out-of-Network
Frequency	Exam 12 Months Lens 12 Months Frames 24 Months	Exam 12 months Lens 12 Months Frames 24 Months
Annual Eye Exam	$10 copay	$35 allowance
Contact Lens Fit and Follow-up	Not to exceed $60	Not Available
Frames	Up to $130 allowance + 20% off any amount above the allowance	$45 allowance
Prescription Lenses		
Single vision	Covered in full after $25 copay	$25 allowance
Bifocal	Covered in full after $25 copay	$40 allowance
Trifocal	Covered in full after $25 copay	$55 allowance
Lenticular	Covered in full after $25 copay	$80 allowance
Contact Lenses		
Medically necessary	Covered in full after $25 copay	Up to $210 allowance
Elective	Up to $135 allowance	Up to $105 allowance

For a complete list of covered services and exclusions, please refer to your "Summary Plan Description."

ADDITIONAL VISION PLAN DETAILS

Additional pairs of glasses

Within 12 months of exam: 20% off unlimited additional pairs of prescription glasses and/or non-prescription sunglasses from an VSP doctor.

VSP Laser VisionCareSM Program

Discounts average 15% off or 5% off a promotional offer for laser surgery, including PRK, Lasik, Custom Lasik, and IntraLase. Discounts are only available from VSP contracted facilities. Also, custom Lasik coverage only available using wavefront technology with the microkeratome surgical devise, other Lasik procedures may be performed at an additional cost to the member.

Low Vision

Pre-approved low vision supplemental testing covered every two years. 75% coverage for approved low vision aids, up to $1,000 (less any amount paid toward supplemental testing) every two years.

Disclaimers and Exclusions

Covered in full materials and services are less any applicable copay. Based on applicable laws, benefits and savings may vary by doctor location. Benefits may also vary at participating retail chains. Promotions like rebates and the featured frame brands promotion are continually evaluated and subject to change without notice. Promotions also do not apply at Costco Optical.

The following items are excluded under this plan: two pairs of glasses instead of bifocals; replacement of lenses, frames, or contacts; medical or surgical treatment; orthoptics; vision training or supplemental testing. Items not covered under the contact lens coverage: insurance policies or service agreements: artistically painted or non-prescription lenses: additional office visits for contact lens pathology; contact lens modification, polishing or cleaning.

PER PAY MEDICAL PREMIUMS

	Tiered PPO Plan	HDHP/HSA Plan
Employee Coverage		
20 Pay Schedule	$134.65	$126.32
24 Pay Schedule	$112.21	$105.27
Employee + Spouse/DP*		
20 Pay Schedule	$323.09	$332.15
24 Pay Schedule	$269.24	$276.79
Employee + 1 or 2 Children		
20 Pay Schedule	$242.35	$332.15
24 Pay Schedule	$201.96	$276.79
Family Coverage*		
20 Pay Schedule	$354.08	$332.15
24 Pay Schedule	$295.07	$276.79

*A per pay surcharge will apply to a spouse/domestic partner who is eligible for medical coverage through their employer but elects Columbus State's plan as primary coverage. The total cost will be $1,200 annually. When you select spousal/domestic coverage in Workday, you will answer a "Yes/No" question about whether or not coverage is provided by their place of employment. If the answer is "Yes", the surcharge will be added to each pay for the plan year.

PER PAY DENTAL AND VISION PREMIUMS

	Delta Dental PPO Plan	Delta Dental Buy-Up Plan	VSP Vision Plan
Employee Coverage			
20 Pay Schedule	$4.81	$6.58	$2.20
24 Pay Schedule	$4.01	$5.48	$1.83
Employee + Spouse/DP			
20 Pay Schedule	$13.65	$12.83	$6.05
24 Pay Schedule	$11.38	$10.69	$5.05
Employee + 1 or 2 Children			
20 Pay Schedule	$13.65	$17.06	$6.05
24 Pay Schedule	$11.38	$14.21	$5.05
Family Coverage			
20 Pay Schedule	$13.65	$23.44	$6.05
24 Pay Schedule	$11.38	$19.53	$5.05

FLEXIBLE SPENDING ACCOUNTS (FSA)

FSAs are a great way to set aside pre-tax dollars for eligible health or dependent care expenses! You can even use your FSA to pay for over-the-counter medications when prescribed by a doctor. **Plan your contributions carefully** – you forfeit any remaining balance at the end of the year.

CONTRIBUTION LIMITS FOR 2025

Health Care & Limited Purpose: $3,300

Dependent Care: $5,000 (or $2,500 if married and filing separately)

HEALTHCARE FSA

LOWER YOUR TAXABLE INCOME

Save taxes on eligible expenses through contributions. It's smart and simple. During open enrollment, add up how much you paid last year for medically necessary family health expenses not covered by the benefit plans:

- Coinsurance
- Copays
- Prescriptions
- Vision
- Dental

Include any new expenses you know you will have this year such as glasses or orthodontia. Now you have an idea of how much to have withheld from your pay when you enroll for the coming year.

You can spend all your annual healthcare account on one large expense the first day your plan is effective. Set your amount carefully. Plan carefully, money you don't spend by the end of the year is forfeited.

ELIGIBLE EXPENSES

Use your Flexible Spending Account funds to pay for a variety of expenses for you, your spouse, and your dependents, but keep in mind the IRS has specific rules about which expenses may be reimbursed by an FSA.

LIMITED PURPOSE FSA

TAX-FREE DOLLARS FOR DENTAL & VISION

The Limited Purpose Flexible Spending Account is a tax-advantaged account available to those that are enrolled in the HDHP with an HSA.

The Limited Purpose FSA allows you to put aside pre-tax money so that you can pay for certain qualified health care expenses including dental and vision expenses.

- Braces
- Laser Eye Surgery
- Dentures & Bridges
- Prescription Sunglasses
- X-ray fees (dental)
- Fillings

Since you can't participate in a traditional Health Care FSA if you contribute to an HSA, you are eligible for the Limited Purpose FSA to increase your tax-saving potential.

DEPENDENT CARE FSA

TAX-FREE DOLLARS FOR DAYCARE EXPENSES

Use this account to pay for daycare, preschool or senior care needed while you and your spouse work, go to school full time, or look for work.

- Child in-home care
- After-school latchkey and or daycare centers
- Senior in-home care
- Summer activities or daycare centers provided while you work
- Nursery schools

Money is deducted from each paycheck and added to your dependent daycare account. You may not be reimbursed more than the current balance. Care while you are not working such as an overnight camp is not eligible. Family members who are not tax dependents may be eligible caregivers*.

*See IRS Publication 503 at IRS.gov

HOW THE PLAN WORKS
FLEXIBLE SPENDING ACCOUNTS

1

DECIDE how much to set aside and ENROLL

The amount you choose is deducted from your pay and added to your account(s)

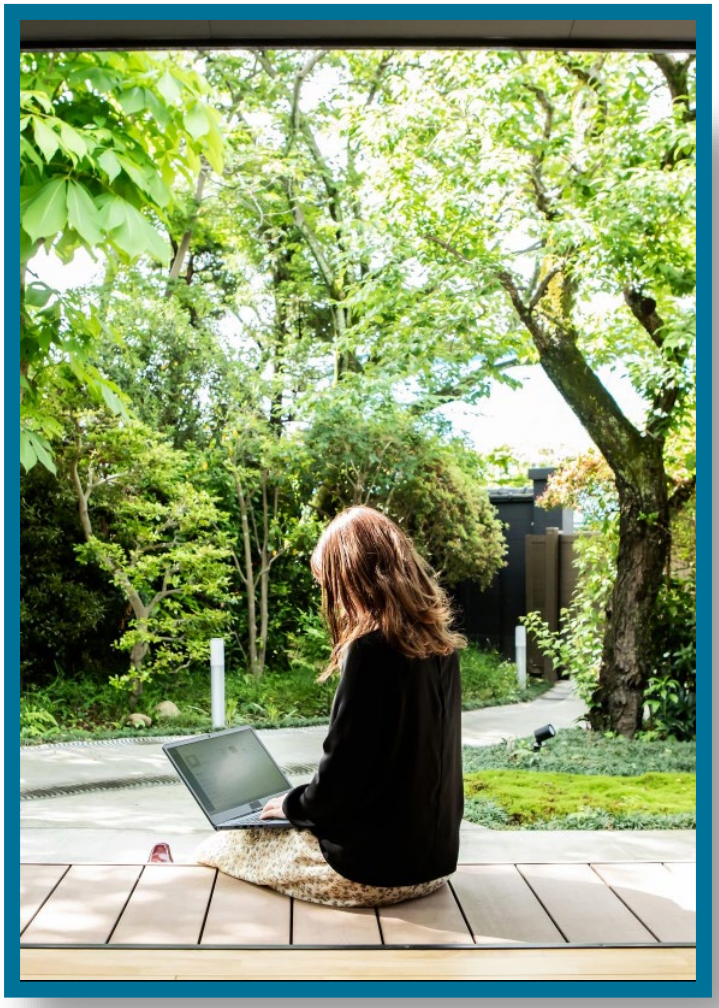
2

THEN CHOOSE one of the OPTIONS

- **Use the FSA debit card to pay for eligible expenses.**
- **Pay for eligible expenses and submit a claim.** You may claim the entire balance of your healthcare account on the first day of the year but only the current balance in the dependent daycare account. Submit copies of itemized receipts, statements or Explanation of Benefits (EOB) with your claim. Receive your payment through direct deposit or check.
- **Submit claims using the mobile app, website, email, fax or mail**. For more information visit/register on www.myuhc.com. You will not owe taxes on your Flexible Spending Account (Social Security, Federal and most state income taxes).

IRS REGULATIONS
FLEXIBLE SPENDING ACCOUNTS

- No matter how you use your FSA funds, the IRS requires proof your claim is for an eligible expense. You may be asked to send us a copy of your receipt, itemized statement, or Explanation of Benefits (EOB) as substantiation for your claim.
- You cannot change your mind after you enroll unless you experience specific work/life events. (See FAQs on CSCC benefit website.)
- Money cannot be transferred from one plan to the other.
- You must spend your money within your plan's filing deadlines.
- Only eligible healthcare and dependent care expenses can be reimbursed (no cosmetic healthcare expenses).
- The dependent FSA plan may not be used for dependent healthcare expenses.
- Once you claim an expense you may not claim it again on your annual taxes.



SUPPLEMENTAL INSURANCE BENEFITS

All full-time employees are eligible for these benefits. If you choose to enroll in these benefits, you pay the full premium cost.

SUPPLEMENTAL LIFE INSURANCE

Columbus State offers you the opportunity to supplement the Basic Life Insurance benefits (equal to two times your annual base earnings, up to a maximum of $500,000) by purchasing additional term life insurance. When you enroll in this benefit, you pay the full cost of the premiums through after-tax payroll deductions. You can choose between one or two times your basic annual earnings. The cost depends on your age and the amount of optional coverage you wish to purchase. Premiums are payroll deducted on a post-tax basis.

SUPPLEMENTAL LIFE INSURANCE PREMIUMS, BASED ON AGE

Monthly cost for each $1,000 of supplemental life insurance coverage

Under 30	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70 and over
$0.06	$0.08	$0.09	$0.10	$0.21	$0.37	$0.50	$0.86	$2.09	$5.43

SUPPLEMENTAL ACCIDENTAL DEATH & DISMEMBERMENT (AD&D)

Accidental Death and Dismemberment can be added at a cost of $0.016 per $1,000 for employee only coverage and can be elected in $10,000 increments.

HOW TO CALCULATE THE PREMIUM

_____	÷ 1,000	x	_____	=	_____	÷ 2	=	_____
Your Elected Coverage Amount			Monthly Cost Based on Age (see table above)		Monthly Deduction			Semi-Monthly Payroll Premium

DEPENDENT LIFE INSURANCE

You may also purchase life insurance for your eligible dependents. Premiums are payroll deducted on a post-tax basis. You are the beneficiary for Dependent Life Insurance. Here are the options you may choose from:

SPOUSE	You may purchase coverage for your spouse in the amount of $10,000 or $20,000.
CHILDREN	You may purchase coverage for your dependent children in the amount of $5,000. The child coverage is $500 for child under six months.

DEPENDENT LIFE INSURANCE PREMIUMS

Dependent Spouse/Child Combined Family Rate:
Option 1 - $10,000 = $2.72 monthly rate
Option 2 - $20,000 = $5.45 monthly rate

AD&D Family Rate:
40% for spouse and 10% for each child
50% for spouse only and 15% each for child(ren) only
Monthly rate of $0.022 per $1,000 of coverage.

EVIDENCE OF INSURABILITY

EOI is an application process in which you provide information on the condition of your health for insurance purposes.

Guaranteed Issue Amount for new hires – Evidence of Insurability is required on amounts which exceed the amount listed below and on all Late Applicants for Contributory coverage.	
Employee	1 x basic annual earnings

NOTE: Any amount elected above the Guaranteed Issue Amount is subject to EOI and approval by Lincoln Financial Group. If you are electing coverage above the Guaranteed Issue Amount, an EOI form must be completed. You can print an EOI form from the HR intranet page.

ACCIDENT INSURANCE

Accidents can lead to trips to the emergency room and the doctor's office, which could amount to bills and expenses not covered by your medical and disability insurance.

Recent studies have shown

$1,233 is the average cost for one visit to the emergency room in the U.S.[1]

With competitive employee rates, you can get Accident High Plan coverage for less than the cost of …

Lunch out,
3x per week,
salad and bottled water

Every day
coffee fix
medium cup

Based on average costs at national retail chains

Monthly
gym membership

How it works

Kathy's daughter, Molly, plays soccer. During a recent game, Molly collided with an opposing player, was knocked unconscious and taken to the local emergency room by ambulance for treatment. The ER doctor diagnosed a fracture after ordering an MRI. After thorough evaluation, Molly was released to her primary care physician for follow-up treatment.

Covered Event[2]	Benefit Amount (Low)	Benefit Amount (High)
Ambulance (ground)	$240	$360
Emergency Care	$225	$275
Physician Follow-up	$60	$100
Major Diagnostic Exam	$125	$275
Medical Equipment	$75	$200
Concussion	$150	$225

What you need to know about Voya's Accident coverage:

- Over 150 covered events and services, such as fractures, dislocations and medical treatments or tests.
- You and your eligible family members are guaranteed coverage[4]. No medical exam and no hassle.
- Lump-sum payment helps cover unexpected costs that result from an accident.
- For your convenience, premiums will be automatically deducted from your paycheck.

To learn more call (877) 236-7564

1. Emergency Rooms vs. Urgent Care Centers. Debt.org. www.debt.org/medical/emergency-room-urgent-care-costs/. Updated May 24, 2018.
2. Covered services/treatments must be the result of a covered accident as defined in the group policy/certificate. See your Disclosure Statement or Outline of Coverage/Disclosure Document for full details.
3. Benefit amount is based on a sample Voya plan design. Actual plan design and plan benefits may vary.
4. Coverage is guaranteed provided (1) the employee is actively at work and (2) dependents to be covered are not subject to medical restrictions as set forth on the enrollment form and in the Certificate. Some states require the insured to have medical coverage. Additional restrictions apply to dependents serving in the armed forces or living overseas.

CRITICAL ILLNESS INSURANCE

Recent studies have shown **Medical bills have contributed to 58% of bankruptcies, while illness-related income loss contributed to 44.3%.**[1]

With competitive employee rates, you can get monthly Critical Illness Insurance coverage for less than the cost of …

Tankful
Of unleaded gas for an SUV

Monthly
Gym membership

2 gallons of milk **per week**

How it works

The example below illustrates various conditions payable for an employee who elected $30,000 dollars of critical illness coverage.

Illness – Covered Condition	Payment
Heart Attack	Benefit payment of $30,000 or 100%
Cancer	Benefit payment of $30,000 or 100%
Stroke	Benefit payment of $30,000 or 100%

Voya Critical Illness Insurance:
$15,000 or $30,000
Benefit Amount

What you need to know about Voya's Critical Illness coverage:

- Over 20 covered critical illnesses, such as Cancer,[2] Heart Attack, Stroke,[3] and Kidney Failure.
- You and your eligible family members are guaranteed coverage during this open enrollment.[4] No medical exam and no hassle.
- Lump-sum payment can be used however you want, including to help cover unexpected costs that result from a covered critical illness.
- For your convenience, premiums will be automatically deducted from your paycheck.

1. Medical Bankruptcy: Still Common Despite the Affordable Care Act.* David U. Himmelstein, Robert M. Lawless, Deborah Thorne, Pamela Foohey, and Steffie Woolhandler. *American Journal of Public Health*, March 1, 2019 (online Feb. 6, 2019).
2. Please review the Disclosure Statement or Outline of Coverage/Disclosure Document for specific information about cancer benefits. Not all types of cancer are covered. Some cancers are covered at less than the Initial Benefit Amount. For NH-sitused cases and NH residents, there is an initial benefit of $100 for All Other Cancer.
3. In certain states, the Covered Condition is Severe Stroke.
4. Coverage is guaranteed provided (1) the employee is actively at work and (2) dependents to be covered are not subject to medical restrictions as set forth on the enrollment form and in the Certificate. Some states require the insured to have medical coverage. Additional restrictions apply to dependents serving in the armed forces or living overseas. [For CA sitused cases, coverage is guaranteed provided (1) the employee is performing all of the usual and customary duties of your job at the employer's place of business or at an alternate place approved by your employer (2) dependents are not subject to medical restrictions as set forth on the enrollment form and in the Certificate.]

CRITICAL ILLNESS INSURANCE

BENEFIT PAYMENT

Your Benefit provides a lump-sum payment upon the diagnosis of a Covered Condition.

Please refer to the table below for the percentage benefit amount for each Covered Condition.

Covered Conditions	Benefit Amount
Cancer[5]	100% of Benefit
Heart Attack	100% of Benefit
Stroke	100% of Benefit
Coronary Artery Bypass	100% of Benefit
Kidney Failure	100% of Benefit
Alzheimer's Disease[9]	100% of Benefit
Major Organ Transplant Benefit	100% of Benefit
And many other payable conditions	

5. Excludes skin cancer, which pays at 10%

HOSPITAL INDEMNITY INSURANCE

People get sick and have accidents. It happens all the time, sometimes requiring a trip to the hospital. Even with medical coverage, additional expenses can add up quickly.

Recent studies have shown **52%** of all personal bankruptcies are a result of medical expenses. The study also reveals that 78% of those who filed had insurance.[1]

With competitive employee rates, you can get Hospital Indemnity High Plan coverage for less than the cost of …

Breakfast out
3x per week,
Coffee with egg sandwich/platter

Monthly
Gym membership

Based on average costs at national retail chains

Movie outing
For group of 4.
Tickets, drink, popcorn and candy

How it works

Susan has chest pains at home and after contacting her doctor she is instructed to head to her local hospital. Upon arrival, the doctor examines Susan and advises that she requires immediate admission to the Intensive Care Unit for further evaluation and treatment. After 2 days in the Intensive Care Unit, Susan moves to a standard room and spends 2 additional days recovering in the hospital. Susan was released to her primary care physician for follow-up treatment. Depending on her health insurance, Susan's out-of-pocket costs could run into hundreds of dollars to cover expenses like insurance copayments and deductibles. Voya Hospital Indemnity Insurance payments can be used to help cover these unexpected costs or in any other way Susan sees fit.

Covered Benefit[2]	Benefit Amount[2] Low Plan	Benefit Amount[2] High Plan
Regular Hospital Admission	$1,000	$2,000
ICU Supplemental Admission	None	None
Regular Hospital Confinement	$100	$200
ICU Supplemental Confinement	$200	$400
Benefits paid by Voya Group Hospital Indemnity Insurance	$1,300	$2,600

What you need to know about Voya's Critical Illness coverage:

- You and your eligible family members are guaranteed coverage during this open enrollment. No medical exam and no hassle.
- Lump-sum payment can be used to help cover unexpected costs that result from a hospitalization.
- For your convenience, premiums will be automatically deducted from your paycheck.

1. 10 Leading Causes of Bankruptcy, 2015 Clear Bankruptcy, LLD. http://www.clearbankruptcy.com/financial-literacy/10-leading causes of bankruptcy.aspx Accessed May, 2015.
2. Benefit amount is based on a sample Voya plan design. Plan design and plan benefits may vary.
3. Coverage is guaranteed provided (1) the employee is actively at work and (2) dependents to be covered are not subject to medical restrictions as set forth on the enrollment form and in the Certificate. Some states require the insured to have medical coverage. Additional restrictions may apply to dependents serving in the armed forces or living overseas.

HOSPITAL INDEMNITY INSURANCE

With Voya, you'll have a choice of two comprehensive plans which provide payments in addition to any other insurance payments you may receive. Here are just some of the covered benefits/services, when an accident or illness puts you in the hospital.[A]

COVERED BENEFITS

Please contact Voya for detailed definitions and state variations of covered benefits.

Subcategory	Benefit Limits	Benefit	Low Plan	High Plan
Admission Benefit	Per admission, up to 2 per year	Admission	$1,000	$2,000
		ICU Supplemental Admission (Benefit paid concurrently with the Admission benefit when a Covered Person is admitted to ICU)	None	None
Confinement Benefit	Up to 10 days	Confinement[1]	$100	$200
		ICU Supplemental Confinement (Benefit paid concurrently with the Confinement benefit when a Covered Person is admitted to ICU)	$100	$200
Additional Benefits	Up to 10 days	Rehabilitation Facility	$50	$100
	Per year	Observation Unit	$100	$100
	Up to 3 days	Maternity Follow-Up	$5	$5

A. Hospital does not include certain facilities such as nursing homes, convalescent care or extended care facilities. See your Disclosure Statement or Outline of Coverage/Disclosure Document for full details.

1. If the Admission Benefit is payable for a Confinement, the Confinement Benefit will begin to be payable the day after Admission.

BENEFITS CONTACT INFORMATION

EXTERNAL CONTACTS

BENEFIT	COMPANY	PHONE	WEBSITE
Cancer Bridge	CancerBridge	855-366-7700	www.mycancerbridge.com
Dental	Delta Dental	800-282-0749	www.deltadentaloh.com
EAP	MATRIX	614-475-9500	www.matrixpsych.com
FSA	UnitedHealthcare	866-755-2648	www.myuhc.com
HSA	Optum Bank	800-243-5543	www.optumbank.com
Life and AD&D	Lincoln Financial Group	877-275-5462	www.lincolnfinancial.com
Long Term Disability	Lincoln Financial Group	877-275-5462	www.lincolnfinancial.com
Medical	UnitedHealthcare	888-252-6420	www.myuhc.com
Vision	VSP	800-877-7195	www.vsp.com
Pet Insurance	Nationwide	855-525-1458	www.petbenefitsportal.com
CI, HI, ACC	Voya	877-236-7564	https://presents.Voya.com/EBRC/CSCC
Identity Theft	Norton LifeLock	800-607-9174	https://Norton.com/premierplus

INTERNAL CONTACTS

BENEFIT	Email
CSCC Benefits Team	benefits@cscc.edu
Family Medical Leave	fml@cscc.edu
Retirement	retirement@cscc.edu
Workplace Injury	workplaceinjury@cscc.edu
Wellness	wellbeing@cscc.edu
Pregnancy Workers Fairness Act	pregnantworkers@cscc.edu

NOTICES

Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit **www.healthcare.gov**.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or **www.insurekidsnow.gov** to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at **www.askebsa.dol.gov** or call **1-866-444-EBSA (3272)**.

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of March 17, 2025. Contact your State for more information on eligibility –

ALABAMA – Medicaid	ALASKA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx OR https://health.alaska.gov/en/services/division-of-public-assistance-services/apply-for-medicaid/
ARKANSAS – Medicaid	**CALIFORNIA – Medicaid**

Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Health Insurance Premium Payment (HIPP) Program Website: http://dhcs.ca.gov/hipp Phone: 916-445-8322 Fax: 916-440-5676 Email: hipp@dhcs.ca.gov
COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	**FLORIDA – Medicaid**
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/State Relay 711 CHP+: https://hcpf.colorado.gov/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.mycohibi.com/ HIBI Customer Service: 1-855-692-6442	Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268
GEORGIA – Medicaid	**INDIANA – Medicaid**
GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162, Press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra Phone: 678-564-1162, Press 2	Health Insurance Premium Payment Program All other Medicaid Website: https://www.in.gov/medicaid/ http://www.in.gov/fssa/dfr/ Family and Social Services Administration Phone: 1-800-403-0864 Member Services Phone: 1-800-457-4584
IOWA – Medicaid and CHIP (Hawki)	**KANSAS – Medicaid**
Medicaid Website: Iowa Medicaid | Health & Human Services Medicaid Phone: 1-800-338-8366 Hawki Website: Hawki - Healthy and Well Kids in Iowa | Health & Human Services Hawki Phone: 1-800-257-8563 HIPP Website: Health Insurance Premium Payment (HIPP) | Health & Human Services (iowa.gov) HIPP Phone: 1-888-346-9562	Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-800-967-4660
KENTUCKY – Medicaid	**LOUISIANA – Medicaid**

Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kynect.ky.gov Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms	Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)

MAINE – Medicaid	MASSACHUSETTS – Medicaid and CHIP
Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=en_US Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-977-6740 TTY: Maine relay 711	Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: 711 Email: masspremassistance@accenture.com
MINNESOTA – Medicaid	**MISSOURI – Medicaid**
Website: https://mn.gov/dhs/health-care-coverage/ Phone: 1-800-657-3672	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005
MONTANA – Medicaid	**NEBRASKA – Medicaid**
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HHSHIPPProgram@mt.gov	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
NEVADA – Medicaid	**NEW HAMPSHIRE – Medicaid**
Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext. 15218 Email: DHHS.ThirdPartyLiabi@dhhs.nh.gov

NEW JERSEY – Medicaid and CHIP	NEW YORK – Medicaid
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Phone: 1-800-356-1561 CHIP Premium Assistance Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710 (TTY: 711)	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
NORTH CAROLINA – Medicaid	**NORTH DAKOTA – Medicaid**
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Website: https://www.hhs.nd.gov/healthcare Phone: 1-844-854-4825

OKLAHOMA – Medicaid and CHIP	OREGON – Medicaid and CHIP
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: http://healthcare.oregon.gov/Pages/index.aspx Phone: 1-800-699-9075
PENNSYLVANIA – Medicaid and CHIP	**RHODE ISLAND – Medicaid and CHIP**
Website: https://www.pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html Phone: 1-800-692-7462 CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov) CHIP Phone: 1-800-986-KIDS (5437)	Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)
SOUTH CAROLINA – Medicaid	**SOUTH DAKOTA - Medicaid**
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://dss.sd.gov Phone: 1-888-828-0059
TEXAS – Medicaid	**UTAH – Medicaid and CHIP**
Website: Health Insurance Premium Payment (HIPP) Program | Texas Health and Human Services Phone: 1-800-440-0493	Utah's Premium Partnership for Health Insurance (UPP) Website: https://medicaid.utah.gov/upp/ Email: upp@utah.gov Phone: 1-888-222-2542 Adult Expansion Website: https://medicaid.utah.gov/expansion/ Utah Medicaid Buyout Program Website: https://medicaid.utah.gov/buyout-program/ CHIP Website: https://chip.utah.gov/
VERMONT– Medicaid	**VIRGINIA – Medicaid and CHIP**

Website: Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access Phone: 1-800-250-8427`	Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs Medicaid/CHIP Phone: 1-800-432-5924 OR 1-855-242-8282
WASHINGTON – Medicaid	**WEST VIRGINIA – Medicaid and CHIP**
Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022	Website: https://dhhr.wv.gov/bms/ http://mywvhipp.com/ Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)

WISCONSIN – Medicaid and CHIP	**WYOMING – Medicaid**
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since March 17, 2025, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

Important notice to employees from Columbus State Community College about creditable prescription drug coverage and Medicare

The purpose of this notice is to advise you that the prescription drug coverage listed below under the Columbus State Community College medical plan are expected to pay out, on average, at least as much as the standard Medicare prescription drug coverage will pay in 2025. This is known as "creditable coverage."

Why this is important. If you or your covered dependent(s) are enrolled in any prescription drug coverage during 2025 listed in this notice and are or become covered by Medicare, you may decide to enroll in a Medicare prescription drug plan later and not be subject to a late enrollment penalty – as long as you had creditable coverage within 63 days of your Medicare prescription drug plan enrollment. You should keep this notice with your important records.

If you or your family members aren't currently covered by Medicare and won't become covered by Medicare in the next 12 months, this notice doesn't apply to you.

Please read the notice below carefully. It has information about prescription drug coverage with Columbus State Community College and prescription drug coverage available for people with Medicare. It also tells you where to find more information to help you make decisions about your prescription drug coverage.

Notice of creditable coverage

You may have heard about Medicare's prescription drug coverage (called Part D), and wondered how it would affect you. Prescription drug coverage is available to everyone with Medicare through Medicare prescription drug plans. All Medicare prescription drug plans provide at least a standard level of coverage set by Medicare. Some plans also offer more coverage for a higher monthly premium.

Individuals can enroll in a Medicare prescription drug plan when they first become eligible, and each year from October 15 through December 7. Individuals leaving employer/union coverage may be eligible for a Medicare Special Enrollment Period.

If you are covered by one of the Columbus State Community College prescription drug plans, you'll be interested to know that the prescription drug coverage under the plans is, on average, at least as good as standard Medicare prescription drug coverage for 2025. This is called creditable coverage. Coverage under one of these plans will help you avoid a late Part D enrollment penalty if you are or become eligible for Medicare and later decide to enroll in a Medicare prescription drug plan.

If you decide to enroll in a Medicare prescription drug plan and you are an active employee or family member of an active employee, you may also continue your employer coverage. In this case, the Columbus State Community College plan will continue to pay primary or secondary as it had before you enrolled in a Medicare prescription drug plan. If you waive or drop Columbus State Community College coverage, Medicare will be your only payer. You can re-enroll in the employer plan at annual enrollment or if you have a special enrollment or other qualifying event or otherwise become newly eligible to enroll in the Columbus State Community College plan mid-year, assuming you remain eligible.

You should know that if you waive or leave coverage with Columbus State Community College and you go 63 days or longer without creditable prescription drug coverage (once your applicable Medicare enrollment period ends), your monthly Part D premium will go up at least 1% per month for every month that you did not have creditable coverage. For example, if you go 19 months without coverage, your Medicare prescription drug plan premium will always be at least 19% higher than what most other people pay. You'll have to pay this higher premium as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to enroll in Part D.

You may receive this notice at other times in the future – such as before the next period you can enroll in Medicare prescription drug coverage, if this Columbus State Community College coverage changes, or upon your request.

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. Medicare participants will get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare prescription drug plans. Here's how to get more information about Medicare prescription drug plans:

- Visit medicare.gov for personalized help.
- Call your State Health Insurance Assistance Program (see a copy of the Medicare & You handbook for the telephone number) or visit the program online at https://www.shiptacenter.org/.
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

For people with limited income and resources, extra help paying for a Medicare prescription drug plan is available. Information about this extra help is available from the Social Security Administration (SSA). For more information about this extra help, visit SSA online at www.socialsecurity.gov or call 1-800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this notice. If you enroll in a Medicare prescription drug plan after your applicable Medicare enrollment period ends, you may need to provide a copy of this notice when you join a Part D plan to show that you are not required to pay a higher Part D premium amount.

For more information about this notice or your prescription drug coverage, contact:

Columbus State Community College Benefits Team at benefits@cscc.edu.

Notice of Special Enrollment Rights for Health plan coverage

As you know, if you have declined enrollment in Columbus State Community College's health plan for you or your dependents (including your spouse) because of other health insurance coverage, you or your dependents may be able to enroll in some coverages under this plan without waiting for the next open enrollment period, provided that you request enrollment within 31 days after your other coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your eligible dependents, provided that you request enrollment within 31 days after the marriage, birth, adoption or placement for adoption.

Columbus State Community College will also allow a special enrollment opportunity if you or your eligible dependents either:

- Lose Medicaid or Children's Health Insurance Program (CHIP) coverage because you are no longer eligible, or
- Become eligible for a state's premium assistance program under Medicaid or CHIP.

For these enrollment opportunities, you will have *60 days* – instead of 31 – from the date of the Medicaid/CHIP eligibility change to request enrollment in the Columbus State Community College group health plan. Note that this new 60-day extension doesn't apply to enrollment opportunities other than due to the Medicaid/CHIP eligibility change.

Note: If your dependent becomes eligible for a special enrollment right, you may add the dependent to your current coverage or change to another health plan.

Women's Health and Cancer Rights Act notice

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. If you would like more information on WHCRA benefits, contact your plan administrator at benefits@cscc.edu.

Newborns' and Mothers' Health Protection Act notice

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours). If you would like more information on maternity benefits, contact your plan administrator at benefits@cscc.edu.

Marketplace/Exchange Notice

Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMB No. 1210-0149
(expires 12-31-2026)

PART A: General Information

Even if you are offered health coverage through your employment, you may have other coverage options through the Health Insurance Marketplace ("Marketplace"). To assist you as you evaluate options for you and your family, this notice provides some basic information about the Health Insurance Marketplace and health coverage offered through your employment.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options in your geographic area.

Can I Save Money on my Health Insurance Premiums in the Marketplace?

You may qualify to save money and lower your monthly premium and other out-of-pocket costs, but only if your employer does not offer coverage, or offers coverage that is not considered affordable for you and doesn't meet certain minimum value standards (discussed below). The savings that you're eligible for depends on your household income. You may also be eligible for a tax credit that lowers your costs.

Does Employment-Based Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that is considered affordable for you and meets certain minimum value standards, you will not be eligible for a tax credit, or advance payment of the tax credit, for your Marketplace coverage and may wish to enroll in your employment-based health plan. However, you may be eligible for a tax credit, and advance payments of the credit that lowers your monthly premium, or a reduction in certain cost-sharing, if your employer does not offer coverage to you at all or does not offer coverage that is considered affordable for you or meet minimum value standards. If your share of the premium cost of all plans offered to you through your employment is more than 9.02% for 2025[1] of your annual household income, or if the coverage through your employment does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit, and advance payment of the credit, if you do not enroll in the employment-based health coverage. For family members of the employee, coverage is considered affordable if the employee's cost of premiums for the lowest-cost plan that would cover all family members does not exceed 9.02% for 2025[2] of the employee's household income.

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered through your employment, then you may lose access to whatever the employer contributes to the employment-based coverage. Also, this employer contribution - as well as your employee contribution to employment-based coverage- is generally excluded from income for federal and state income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis. In addition, note that if the health coverage offered through your employment does not meet the affordability or minimum value standards, but you accept that coverage anyway, you will not be eligible for a tax credit. You should consider all of these factors in determining whether to purchase a health plan through the Marketplace.

When Can I Enroll in Health Insurance Coverage through the Marketplace?

You can enroll in a Marketplace health insurance plan during the annual Marketplace Open Enrollment Period. Open Enrollment varies by state but generally starts November 1 and continues through at least December 15.

Outside the annual Open Enrollment Period, you can sign up for health insurance if you qualify for a Special Enrollment Period. In general, you qualify for a Special Enrollment Period if you've had certain qualifying life events, such as getting married, having a baby, adopting a child, or losing eligibility for other health coverage. Depending on your Special Enrollment Period type, you may have 60 days before or 60 days following the qualifying life event to enroll in a Marketplace plan.

[1] Indexed annually; see https://www.irs.gov/pub/irs-drop/rp-24-35.pdf for 2025.

[2] An employer-sponsored or other employment-based health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs. For purposes of eligibility for the premium tax credit, to meet the "minimum value standard," the health plan must also provide substantial coverage of both inpatient hospital services and physician services.

There is also a Marketplace Special Enrollment Period for individuals and their families who lose eligibility for Medicaid or Children's Health Insurance Program (CHIP) coverage on or after March 31, 2023, through July 31, 2024. Since the onset of the nationwide COVID-19 public health emergency, state Medicaid and CHIP agencies generally have not terminated the enrollment of any Medicaid or CHIP beneficiary who was enrolled on or after March 18, 2020, through March 31, 2023. As state Medicaid and CHIP agencies resume regular eligibility and enrollment practices, many individuals may no longer be eligible for Medicaid or CHIP coverage starting as early as March 31, 2023. The U.S. Department of Health and Human Services **is offering a temporary Marketplace Special Enrollment period to allow these individuals to enroll in Marketplace coverage.**

Marketplace-eligible individuals who live in states served by HealthCare.gov and either- submit a new application or update an existing application on HealthCare.gov between March 31, 2023 and July 31, 2024, and attest to a termination date of Medicaid or CHIP coverage within the same time period, are eligible for a 60-day Special Enrollment Period. **That means that if you lose Medicaid or CHIP coverage between March 31, 2023, and July 31, 2024, you may be able to enroll in Marketplace coverage within 60 days of when you lost Medicaid or CHIP coverage.** In addition, if you or your family members are enrolled in Medicaid or CHIP coverage, it is important to make sure that your contact information is up to date to make sure you get any information about changes to your eligibility. To learn more, visit HealthCare.gov or call the Marketplace Call Center at 1-800-318-2596. TTY users can call 1-855-889-4325.

What about Alternatives to Marketplace Health Insurance Coverage?

If you or your family are eligible for coverage in an employment-based health plan (such as an employer-sponsored health plan), you or your family may also be eligible for a Special Enrollment Period to enroll in that health plan in certain circumstances, including if you or your dependents were enrolled in Medicaid or CHIP coverage and lost that coverage. Generally, you have 60 days after the loss of Medicaid or CHIP coverage to enroll in an employment-based health plan, but if you and your family lost eligibility for Medicaid or CHIP coverage between March 31, 2023 and July 10, 2023, you can request this special enrollment in the employment-based health plan through September 8, 2023. Confirm the deadline with your employer or your employment-based health plan.

Alternatively, you can enroll in Medicaid or CHIP coverage at any time by filling out an application through the Marketplace or applying directly through your state Medicaid agency. Visit https://www.healthcare.gov/medicaid-chip/getting-medicaid-chip/ for more details.

How Can I Get More Information?

For more information about your coverage offered through your employment, please check your health plan's summary plan description or contact benefits@cscc.edu.

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit **HealthCare.gov** for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

PART B: Information About Health Coverage Offered by Your Employer

This section contains information about any health coverage offered by your employer. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information. This information is numbered to correspond to the Marketplace application.

<table>
<tr><td colspan="2">3. Employer name:
Columbus State Community College</td><td colspan="2">4. Employer Identification Number (EIN):
311391013</td></tr>
<tr><td colspan="2">5. Employer address:
550 East Spring Street</td><td colspan="2">6. Employer phone number:
614-287-2400</td></tr>
<tr><td colspan="2">7. City: Columbus</td><td>8. State: OH</td><td>9. Zip code: 43215</td></tr>
<tr><td colspan="4">10. Who can we contact about employee health coverage at this job?
Columbus State Community College - Benefits Team</td></tr>
<tr><td colspan="2">11. Phone number (if different from above)
614-287-5353</td><td colspan="2">12. Email address: benefits@cscc.edu</td></tr>
</table>

Here is some basic information about health coverage offered by this employer:

- As your employer, we offer a health plan to:

  ☐ All employees. Eligible employees are:

  ☒ Some employees. Eligible employees are regular full-time employees

- With respect to dependents:

  ☒ We do offer coverage. Eligible dependents are: your Spouse and/or Domestic Partner, your or your spouse's child who is under age 26, including a natural child, stepchild, a legally adopted child, a child placed for adoption or a child for whom you or your Spouse are the legal guardian, or an unmarried child age 26 or over who is or becomes disabled and dependent upon you while covered under the plan.

  ☐ We do not offer coverage.

  ☒ If checked, this coverage meets the minimum value standard, and the cost of this coverage to you is intended to be affordable, based on employee wages.

** Even if your employer intends your coverage to be affordable, you may still be eligible for a premium discount through the Marketplace. The Marketplace will use your household income, along with other factors, to determine whether you may be eligible for a premium discount. If, for example, your wages vary from week to week (perhaps you are an hourly employee or you work on a commission basis), if you are newly employed mid-year, or if you have other income losses, you may still qualify for a premium discount.

If you decide to shop for coverage in the Marketplace, **HealthCare.gov** will guide you through the process. Here's the employer information you'll enter when you visit **HealthCare.gov** to find out if you can get a tax credit to lower your monthly premiums.

Columbus State Community College HIPAA privacy notice

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

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) imposes numerous requirements on the use and disclosure of individual health information by Columbus State Community College health plans. This information, known as protected health information, includes almost all individually identifiable health information held by a plan — whether received in writing, in an electronic medium, or as an oral communication. This notice describes the privacy practices of these plans: Columbus State Community College Health Plans. The plans covered by this notice may share health information with each other to carry out treatment, payment, or health care operations. These plans are collectively referred to as the Plan in this notice, unless specified otherwise.

The Plan's duties with respect to health information about you

The Plan is required by law to maintain the privacy of your health information and to provide you with this notice of the Plan's legal duties and privacy practices with respect to your health information. If you participate in an insured plan option, you will receive a notice directly from the Insurer. It's important to note that these rules apply to the Plan, not Columbus State Community College as an employer — that's the way the HIPAA rules work. Different policies may apply to other Columbus State Community College programs or to data unrelated to the Plan.

How the Plan may use or disclose your health information

The privacy rules generally allow the use and disclosure of your health information without your permission (known as an authorization) for purposes of health care treatment, payment activities, and health care operations. Here are some examples of what that might entail:

- **Treatment** includes providing, coordinating, or managing health care by one or more health care providers or doctors. Treatment can also include coordination or management of care between a provider and a third party, and consultation and referrals between providers. For example, the Plan may share your health information with physicians who are treating you.
- **Payment** includes activities by this Plan, other plans, or providers to obtain premiums, make coverage determinations, and provide reimbursement for health care. This can include determining eligibility, reviewing services for medical necessity or appropriateness, engaging in utilization management activities, claims management, and billing; as well as performing "behind the scenes" plan functions, such as risk adjustment, collection, or reinsurance. For example, the Plan may share information about your coverage or the expenses you have incurred with another health plan to coordinate payment of benefits.
- **Health care operations** include activities by this Plan (and, in limited circumstances, by other plans or providers), such as wellness and risk assessment programs, quality assessment and improvement activities, customer service, and internal grievance resolution. Health care operations also include evaluating vendors; engaging in credentialing, training, and accreditation activities; performing underwriting or premium rating; arranging for medical review and audit activities; and conducting business planning and development. For example, the Plan may use information about your claims to audit the third parties that approve payment for Plan benefits.

The amount of health information used, disclosed or requested will be limited and, when needed, restricted to the minimum necessary to accomplish the intended purposes, as defined under the HIPAA rules. If the Plan uses or discloses PHI for underwriting purposes, the Plan will not use or disclose PHI that is your genetic information for such purposes.

How the Plan may share your health information with Columbus State Community College

The Plan, or its health insurer or HMO, may disclose your health information without your written authorization to Columbus State Community College for plan administration purposes. Columbus State Community College may need your health information to administer benefits under the Plan. Columbus State Community College agrees not to use or disclose your health information other than as permitted or required by the Plan documents and by law. Human Resources, Accounting and Employee Health are the only Columbus State Community College employees who will have access to your health information for plan administration functions.

Here's how additional information may be shared between the Plan and Columbus State Community College, as allowed under the HIPAA rules:

- The Plan, or its insurer or HMO, may disclose "summary health information" to Columbus State Community College, if requested, for purposes of obtaining premium bids to provide coverage under the Plan or for modifying, amending, or terminating the Plan. Summary health information is information that summarizes participants' claims information, from which names and other identifying information have been removed.
- The Plan, or its insurer or HMO, may disclose to Columbus State Community College information on whether an individual is participating in the Plan or has enrolled or disenrolled in an insurance option or HMO offered by the Plan.

In addition, you should know that Columbus State Community College cannot and will not use health information obtained from the Plan for any employment-related actions. However, health information collected by Columbus State Community College from other sources — for example, under the Family and Medical Leave Act, Americans with Disabilities Act, or workers' compensation programs — is *not* protected under HIPAA (although this type of information may be protected under other federal or state laws).

Other allowable uses or disclosures of your health information

In certain cases, your health information can be disclosed without authorization to a family member, close friend, or other person you identify who is involved in your care or payment for your care. Information about your location, general condition, or death may be provided to a similar person (or to a public or private entity authorized to assist in disaster relief efforts). You'll generally be given the chance to agree or object to these disclosures (although exceptions may be made — for example, if you're not present or if you're incapacitated). In addition, your health information may be disclosed without authorization to your legal representative.

The Plan also is allowed to use or disclose your health information without your written authorization for the following activities:

Workers' compensation	Disclosures to workers' compensation or similar legal programs that provide benefits for work-related injuries or illness without regard to fault, as authorized by and necessary to comply with the laws
Necessary to prevent serious threat to health or safety	Disclosures made in the good-faith belief that releasing your health information is necessary to prevent or lessen a serious and imminent threat to public or personal health or safety, if made to someone reasonably able to prevent or lessen the threat (or to the target of the threat); includes disclosures to help law enforcement officials identify or apprehend an individual who has admitted participation in a violent crime that the Plan reasonably believes may have caused serious physical harm to a victim, or where it appears the individual has escaped from prison or from lawful custody
Public health activities	Disclosures authorized by law to persons who may be at risk of contracting or spreading a disease or condition; disclosures to public health authorities to prevent or control disease or report child abuse or neglect; and disclosures to the Food and Drug Administration to collect or report adverse events or product defects
Victims of abuse, neglect, or domestic violence	Disclosures to government authorities, including social services or protective services agencies authorized by law to receive reports of abuse, neglect, or domestic violence, as required by law or if you agree or the Plan believes that disclosure is necessary to prevent serious harm to you or potential victims (you'll be notified of the Plan's disclosure if informing you won't put you at further risk)
Judicial and administrative proceedings	Disclosures in response to a court or administrative order, subpoena, discovery request, or other lawful process (the Plan may be required to notify you of the request or receive satisfactory assurance from the party seeking your health information that efforts were made to notify you or to obtain a qualified protective order concerning the information)
Law enforcement purposes	Disclosures to law enforcement officials required by law or legal process, or to identify a suspect, fugitive, witness, or missing person; disclosures about a crime victim if you agree or if disclosure is necessary for immediate law enforcement activity; disclosures about a death that may have resulted from criminal conduct; and disclosures to provide evidence of criminal conduct on the Plan's premises

Decedents	Disclosures to a coroner or medical examiner to identify the deceased or determine cause of death; and to funeral directors to carry out their duties
Organ, eye, or tissue donation	Disclosures to organ procurement organizations or other entities to facilitate organ, eye, or tissue donation and transplantation after death
Research purposes	Disclosures subject to approval by institutional or private privacy review boards, subject to certain assurances and representations by researchers about the necessity of using your health information and the treatment of the information during a research project
Health oversight activities	Disclosures to health agencies for activities authorized by law (audits, inspections, investigations, or licensing actions) for oversight of the health care system, government benefits programs for which health information is relevant to beneficiary eligibility, and compliance with regulatory programs or civil rights laws
Specialized government functions	Disclosures about individuals who are Armed Forces personnel or foreign military personnel under appropriate military command; disclosures to authorized federal officials for national security or intelligence activities; and disclosures to correctional facilities or custodial law enforcement officials about inmates
HHS investigations	Disclosures of your health information to the Department of Health and Human Services to investigate or determine the Plan's compliance with the HIPAA privacy rule

Except as described in this notice, other uses and disclosures will be made only with your written authorization. For example, in most cases, the Plan will obtain your authorization before it communicates with you about products or programs if the Plan is being paid to make those communications. If we keep psychotherapy notes in our records, we will obtain your authorization in some cases before we release those records. The Plan will never sell your health information unless you have authorized us to do so. You may revoke your authorization as allowed under the HIPAA rules. However, you can't revoke your authorization with respect to disclosures the Plan has already made. You will be notified of any unauthorized access, use, or disclosure of your unsecured health information as required by law.

The Plan will notify you if it becomes aware that there has been a loss of your health information in a manner that could compromise the privacy of your health information.

Your individual rights

You have the following rights with respect to your health information the Plan maintains. These rights are subject to certain limitations, as discussed below. This section of the notice describes how you may exercise each individual right. See the table at the end of this notice for information on how to submit requests.

Right to request restrictions on certain uses and disclosures of your health information and the Plan's right to refuse

You have the right to ask the Plan to restrict the use and disclosure of your health information for treatment, payment, or health care operations, except for uses or disclosures required by law. You have the right to ask the Plan to restrict the use and disclosure of your health information to family members, close friends, or other persons you identify as being involved in your care or payment for your care. You also have the right to ask the Plan to restrict use and disclosure of health information to notify those persons of your location, general condition, or death — or to coordinate those efforts with entities assisting in disaster relief efforts. If you want to exercise this right, your request to the Plan must be in writing.

The Plan is not required to agree to a requested restriction. If the Plan does agree, a restriction may later be terminated by your written request, by agreement between you and the Plan (including an oral agreement), or unilaterally by the Plan for health information created or received after you're notified that the Plan has removed the restrictions. The Plan may also disclose health information about you if you need emergency treatment, even if the Plan has agreed to a restriction.

An entity covered by these HIPAA rules (such as your health care provider) or its business associate must comply with your request that health information regarding a specific health care item or service not be disclosed to the Plan for purposes of payment or health care operations if you have paid out of pocket and in full for the item or service.

Right to receive confidential communications of your health information

If you think that disclosure of your health information by the usual means could endanger you in some way, the Plan will accommodate reasonable requests to receive communications of health information from the Plan by alternative means or at alternative locations.

If you want to exercise this right, your request to the Plan must be in writing and you must include a statement that disclosure of all or part of the information could endanger you.

Right to inspect and copy your health information

With certain exceptions, you have the right to inspect or obtain a copy of your health information in a "designated record set." This may include medical, and billing records maintained for a health care provider; enrollment, payment, claims adjudication, and case or medical management record systems maintained by a plan; or a group of records the Plan uses to make decisions about individuals. However, you do not have a right to inspect or obtain copies of psychotherapy notes or information compiled for civil, criminal, or administrative proceedings. The Plan may deny your right to access, although in certain circumstances, you may request a review of the denial.

If you want to exercise this right, your request to the Plan must be in writing. Within 30 days of receipt of your request (60 days if the health information is not accessible on site), the Plan will provide you with one of these responses:

- The access or copies you requested
- A written denial that explains why your request was denied and any rights you may have to have the denial reviewed or file a complaint
- A written statement that the time period for reviewing your request will be extended for no more than 30 more days, along with the reasons for the delay and the date by which the Plan expects to address your request

You may also request your health information be sent to another entity or person, so long as that request is clear, conspicuous and specific. The Plan may provide you with a summary or explanation of the information instead of access to or copies of your health information, if you agree in advance and pay any applicable fees. The Plan also may charge reasonable fees for copies or postage. If the Plan doesn't maintain the health information but knows where it is maintained, you will be informed where to direct your request.

If the Plan keeps your records in an electronic format, you may request an electronic copy of your health information in a form and format readily producible by the Plan. You may also request that such electronic health information be sent to another entity or person, so long as that request is clear, conspicuous, and specific. Any charge that is assessed to you for these copies must be reasonable and based on the Plan's cost.

Right to amend your health information that is inaccurate or incomplete

With certain exceptions, you have a right to request that the Plan amend your health information in a designated record set. The Plan may deny your request for a number of reasons. For example, your request may be denied if the health information is accurate and complete, was not created by the Plan (unless the person or entity that created the information is no longer available), is not part of the designated record set, or is not available for inspection (e.g., psychotherapy notes or information compiled for civil, criminal, or administrative proceedings).

If you want to exercise this right, your request to the Plan must be in writing, and you must include a statement to support the requested amendment. Within 60 days of receipt of your request, the Plan will take one of these actions:

- Make the amendment as requested
- Provide a written denial that explains why your request was denied and any rights you may have to disagree or file a complaint
- Provide a written statement that the time period for reviewing your request will be extended for no more than 30 more days, along with the reasons for the delay and the date by which the Plan expects to address your request

Right to receive an accounting of disclosures of your health information

You have the right to a list of certain disclosures of your health information the Plan has made. This is often referred to as an "accounting of disclosures." You generally may receive this accounting if the disclosure is required by law, in connection with public health activities, or in similar situations listed in the table earlier in this notice, unless otherwise indicated below.

You may receive information on disclosures of your health information for up to six years before the date of your request. You do not have a right to receive an accounting of any disclosures made in any of these circumstances:

- For treatment, payment, or health care operations
- To you about your own health information
- Incidental to other permitted or required disclosures
- Where authorization was provided
- To family members or friends involved in your care (where disclosure is permitted without authorization)
- For national security or intelligence purposes or to correctional institutions or law enforcement officials in certain circumstances
- As part of a "limited data set" (health information that excludes certain identifying information)

In addition, your right to an accounting of disclosures to a health oversight agency or law enforcement official may be suspended at the request of the agency or official.

If you want to exercise this right, your request to the Plan must be in writing. Within 60 days of the request, the Plan will provide you with the list of disclosures or a written statement that the time period for providing this list will be extended for no more than 30 more days, along with the reasons for the delay and the date by which the Plan expects to address your request. You may make one request in any 12-month period at no cost to you, but the Plan may charge a fee for subsequent requests. You'll be notified of the fee in advance and have the opportunity to change or revoke your request.

Right to obtain a paper copy of this notice from the Plan upon request

You have the right to obtain a paper copy of this privacy notice upon request. Even individuals who agreed to receive this notice electronically may request a paper copy at any time.

Changes to the information in this notice

The Plan must abide by the terms of the privacy notice currently in effect. This notice takes effect immediately. However, the Plan reserves the right to change the terms of its privacy policies, as described in this notice, at any time and to make new provisions effective for all health information that the Plan maintains. This includes health information that was previously created or received, not just health information created or received after the policy is changed. If changes are made to the Plan's privacy policies described in this notice, you will be provided with a revised privacy notice posted on the Columbus State Community College intranet.

Complaints

If you believe your privacy rights have been violated or your Plan has not followed its legal obligations under HIPAA, you may complain to the Plan and to the Secretary of Health and Human Services. You won't be retaliated against for filing a complaint. To file a complaint, reach out to the Columbus State Community College Benefits team at benefits@cscc.edu.

Contact

For more information on the Plan's privacy policies or your rights under HIPAA, contact Columbus State Community College Benefits team at benefits@cscc.edu.

Provider-Choice rights notice

The Columbus State Community College medical plans generally allow the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact Columbus State Community College Benefits team at benefits@cscc.edu.

For children, you may designate a pediatrician as the primary care provider.

You do not need prior authorization from the Columbus State Community College medical plans or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact Columbus State Community College Benefits team at benefits@cscc.edu.

Fixed Indemnity Plan Notice

IMPORTANT: This is a fixed indemnity policy, NOT health insurance

This fixed indemnity policy may pay you a limited dollar amount if you're sick or hospitalized. You're still responsible for paying the cost of your care.

- The payment you get isn't based on the size of your medical bill.
- There might be a limit on how much this policy will pay each year.
- This policy isn't a substitute for comprehensive health insurance.
- Since this policy isn't health insurance, it doesn't have to include most federal consumer protections that apply to health insurance.

Looking for comprehensive health insurance?

- **Visit HealthCare.gov** or call **1-800-318-2596** (TTY: 1-855-889-4325) to find health coverage options.
- To find out if you can get health insurance through your job, or a family member's job, contact the employer.

Questions about this policy?

- For questions or complaints about this policy, contact your state Department of Insurance. Find their number on the National Association of Insurance Commissioners' website (**naic.org**) under "Insurance Departments."
- If you have this policy through your job, or a family member's job, contact the employer.

COBRA continuation coverage general notice

Introduction

You're getting this notice because you recently gained coverage under a group health plan (the Plan). This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it.** When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end. For more information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

What is COBRA continuation coverage?

COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you're an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you're the spouse of an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because of the following qualifying events:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Plan as a "dependent child."

When is COBRA continuation coverage available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. The employer must notify the Plan Administrator of the following qualifying events:

- The end of employment or reduction of hours of employment;
- Death of the employee;
- The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. You must provide this notice to: CSCC's Third Party Administrator for COBRA.

How is COBRA continuation coverage provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

There are also ways in which this 18-month period of COBRA continuation coverage can be extended:

Disability extension of 18-month period of COBRA continuation coverage

If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage.

Second qualifying event extension of 18-month period of continuation coverage

If your family experiences another qualifying event during the 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the Plan is properly notified about the second qualifying event. This extension may be available to the spouse and any dependent children getting COBRA continuation coverage if the employee or former employee dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); gets divorced or legally separated; or if the dependent child stops being eligible under the Plan as a dependent child. This extension is only available if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

Are there other coverage options besides COBRA continuation coverage?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicare, Medicaid, Children's Health Insurance Program (CHIP), or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at **www.healthcare.gov.**

Can I enroll in Medicare instead of COBRA continuation coverage after my group health plan coverage ends?

In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period3 to sign up for Medicare Part A or B, beginning on the earlier of

- The month after your employment ends; or
- The month after group health plan coverage based on current employment ends.

If you don't enroll in Medicare and elect COBRA continuation coverage instead, you may have to pay a Part B late enrollment penalty and you may have a gap in coverage if you decide you want Part B later. If you elect COBRA continuation coverage and later enroll in Medicare Part A or B before the COBRA continuation coverage ends, the Plan may terminate your continuation coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if you enroll in the other part of Medicare after the date of the election of COBRA coverage.

If you are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer) and COBRA continuation coverage will pay second. Certain plans may pay as if secondary to Medicare, even if you are not enrolled in Medicare.

For more information visit https://www.medicare.gov/medicare-and-you.

If you have questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit **www.dol.gov/ebsa**. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit **www.HealthCare.gov**.

Keep your Plan informed of address changes

To protect your family's rights, let the Plan Administrator know about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Plan contact information

Columbus State Community College Benefits team at benefits@cscc.edu.

[3] https://www.medicare.gov/sign-up-change-plans/how-do-i-get-parts-a-b/part-a-part-b-sign-up-periods.

No Surprises Act notice

Your Rights and Protections Against Surprise Medical Bills

When you get emergency care or are treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from balance billing. In these cases, you shouldn't be charged more than your plan's copayments, coinsurance and/or deductible.

What is "balance billing" (sometimes called "surprise billing")?

When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, like a copayment, coinsurance, or deductible. You may have additional costs or have to pay the entire bill if you see a provider or visit a health care facility that isn't in your health plan's network.

"Out-of-network" means providers and facilities that haven't signed a contract with your health plan to provide services. Out-of-network providers may be allowed to bill you for the difference between what your plan pays and the full amount charged for a service. This is called "**balance billing**." This amount is likely more than in-network costs for the same service and might not count toward your plan's deductible or annual out-of-pocket limit.

"Surprise billing" is an unexpected balance bill. This can happen when you can't control who is involved in your care—like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider. Surprise medical bills could cost thousands of dollars depending on the procedure or service.

You're protected from balance billing for:

Emergency services

If you have an emergency medical condition and get emergency services from an out-of-network provider or facility, the most they can bill you is your plan's in-network cost-sharing amount (such as copayments, coinsurance, and deductibles). You **can't** be balance billed for these emergency services. This includes services you may get after you're in stable condition, unless you give written consent and give up your protections not to be balanced billed for these post-stabilization services.

Certain services at an in-network hospital or ambulatory surgical center

When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers can bill you is your plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers **can't** balance bill you and may **not** ask you to give up your protections not to be balance billed.

If you get other types of services at these in-network facilities, out-of-network providers **can't** balance bill you, unless you give written consent and give up your protections.

You're never required to give up your protections from balance billing. You also aren't required to get out-of-network care. You can choose a provider or facility in your plan's network.

When balance billing isn't allowed, you also have these protections:

- You're only responsible for paying your share of the cost (like the copayments, coinsurance, and deductible that you would pay if the provider or facility was in-network). Your health plan will pay any additional costs to out-of-network providers and facilities directly.
- Generally, your health plan must:
  - Cover emergency services without requiring you to get approval for services in advance (also known as "prior authorization").
  - Cover emergency services by out-of-network providers.
  - Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits.

- Count any amount you pay for emergency services or out-of-network services toward your in-network deductible and out-of-pocket limit.

If you think you've been wrongly billed, contact U.S. Department of Health and Human Services. The federal phone number for information and complaints is: 1-800-985-3059. Visit No Surprises Act | CMS for more information about your rights under federal law.