EMPLOYEE BENEFITS OPEN ENROLLMENT 2020-21

Full-Time Faculty and Staff

and Part-Time Administrative Faculty and Staff 30-39 Hours

CONFIRM YOUR BENEFITS TODAY!

EMPLOYEE BENEFITS
ANNUAL OPEN ENROLLMENT
BEGINS MAY 20
CLOSES JUNE 3

CHANGES ARE EFFECTIVE
JULY 1, 2020

mycsu.csuohio.edu/offices/hrd/benefits.html

FACULTY/STAFF BENEFITS ELIGIBILITY

The following classification of employees are eligible to participate in the University's employee benefit plans and programs:

- Full-time faculty and staff with an appointment of six (6) months or longer.
- Part-time administrative faculty and staff with an appointment of six (6) months or longer who are scheduled to work 30-39 hours.

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OPEN ENROLLMENT CHECKLISTS

Open Enrollment is your annual opportunity to review your health plans, make changes, add or remove dependents, enroll in a flexible spending account and verify your life insurance beneficiaries. Changes you make to your health plan elections are effective July 1, 2020. The next opportunity to make changes to your health benefits will be the next annual open enrollment period in 2021, unless you experience a change in status (refer to page 3 of this booklet). Changes to your life insurance beneficiaries may be made online during the open enrollment period, however, you can make changes any time during the year by completing a beneficiary change form.

Review Plan and Premium Changes

Medical and Dental plan provisions are changing effective July 1. Medical plan premium contributions are increasing July 1. See inside for details.

REVIEW YOUR ENROLLMENTS AND ELECTION OPPORTUNITIES

Please review your open enrollment options carefully in order to confirm your elections in myBenefits for the new plan year.

❒ **Log into myBenefits, the online enrollment application** (Instructions to access the application are included on the next page).

❒ **Review and update dependents and beneficiaries**
- REMOVE DEPENDENTS FROM COVERAGE – no documentation necessary
- ADD DEPENDENTS TO COVERAGE – required documentation must be provided to the Department of Human Resources by June 4
- ADD AND/OR CHANGE BENEFICIARIES

❒ **Re-enroll/Enroll in a Flexible Spending Account if you wish to participate July 1, 2020-June 30, 2021. Enrollments from the prior plan year do not carry over (Refer to page 13 of this booklet).**

❒ **Current Supplemental Life Insurance participants may take advantage of the open enrollment opportunity to increase coverage without evidence of insurability (refer to page 14 of this booklet for details).**

❒ **Click "edit" on each "type of benefit" to view your options and make changes as desired**

❒ **Complete the two-step process to finalize your enrollment**
- REVIEW AND EDIT YOUR FINAL CHOICES, THEN CLICK "VERIFY"
- WHEN SATISFIED ELECTIONS ARE CORRECT, CLICK "SUBMIT"

❒ **Print a hard copy or save a PDF of your submitted enrollment as confirmation of your changes.**

HOW TO ENROLL

*You will use CSU's **myBenefits online enrollment application** for eligible employee benefit changes* during the FY 2020-2021 annual Open Enrollment period (May 20, 2020 – June 3, 2020).

myBenefits makes open enrollment easy for you by providing a paperless, personalized enrollment process to review your current benefit coverage, dependents, beneficiaries and options available for enrollment and/or changes.

myBenefits Access:

To begin enrollment using the myBenefits online enrollment application:

- Access the CSU home page at www.csuohio.edu from your internet browser
- Click the orange myCSU icon
  ***NOTE:** When accessing myCSU, you may be required to use your CampusNet ID and CampusPass to login.*
- Select "Employee Self-Service" under the "Faculty & Staff" section
- Select "myProfile" and log in using your CSU ID and CampusPass information
- Click "Benefits Details"
- Click "myBenefits Enrollment" to access the online application

Saving Your Enrollment

During the enrollment process, you must click "Save" after adding a new dependent and/or beneficiary, selecting a new plan option and/or entering a change to your current enrollment. Saved changes will be processed after completing a two-step process that finalizes your enrollment.

Finalizing Your Enrollment

A key component of the application requires you to complete a two-step process to finalize your enrollment:

(1) Verify Enrollment – Once you have completed your benefit plan selections and/or changes, you must click "Verify." This is your opportunity to review and edit your final choices.

(2) Submit Enrollment – You must click on "Submit" to finalize the enrollment process and assign your electronic signature.

The two-step process must be completed before the 11:59 p.m. EDT deadline on Wednesday, June 3, 2020, the close of Open Enrollment, for changes to be processed and effective July 1, 2020.

Exiting myBenefits – Before Finalizing Enrollment

You may exit or sign off of myBenefits before completing the two-step process to finalize your enrollment without losing your "saved" data. Upon returning to saved data in the application, additional changes can be entered and "saved" and/or you can complete the two-step process to finalize your benefits. You may enroll and update your elections as many times as you want during the annual open enrollment period. The last selections you "submit" before the 11:59 p.m. EDT deadline on Wednesday, June 3, 2020, will be the benefits that will become effective on July 1, 2020.

You can access myBenefits through myCSU on the University's home page at csuohio.edu

SYSTEM AVAILABILITY

Due to weekly University system maintenance, the myBenefits enrollment application is not available beginning at 6 p.m. each Saturday until 10 a.m. on Sunday.

NEED HELP ENROLLING USING MYBENEFITS?

Contact Human Resources if you need help navigating myBenefits or help enrolling. Send an email to benefits@csuohio.edu with your name, CSU ID# and the phone number where you can be contacted.

HAVING DIFFICULTY ACCESSING MYBENEFITS FROM YOUR COMPUTER?

If you are experiencing difficulties with accessing the myBenefits online enrollment application, contact the IS&T Help Desk at (216) 687-5050.

Updating Your Information

If you have a change in the following, you can make updates to information through **myProfile** in the Employee Self-Service section of myCSU:

- Personal information
- Home and/or campus addresses
- Phone numbers
- Email addresses
- Emergency contact information
- Marital status

Changes to your information for the following should be submitted to Human Resources:

- Education level (after obtaining a new degree)
- Life insurance beneficiary (during the year)

For changes to your Retirement Plan information (addresses, beneficiaries, etc.), make them directly with:

- State Retirement Systems (OPERS /STRS)
- Alternative Retirement Plan providers
- 403(b) providers
- 457 Plan provider

DEPENDENT BENEFITS ELIGIBILITY

The following are eligibility rules, guidelines and documentation requirements for enrollment of qualifying dependents in Cleveland State University's group benefit plans, including provisions of Federal legislation for adult children. Adult children can be covered under the Plan until they attain age 26, regardless of their student or marital status and regardless of whether they live at home or whether you support them.

DEPENDENT TYPE	Eligibility Requirement	Plan Coverage	Documentation Requirement
Spouse	**Husband or wife of a covered employee**	• Medical • Dental • Vision • Supplemental Life Insurance	• State issued marriage certificate • Federal tax return issued within last 2 years
Same-Sex Domestic Partner	**A person of same gender who meets the following criteria:** • Shares a residence with an eligible employee for at least 6 months • At least 18 years of age • Is not related to the employee by blood to a degree of closeness that would prohibit legal marriage • Listed as Domestic Partner on the most recent notarized CSU Affidavit of Domestic Partnership • Is not in relationship solely for the purpose of obtaining benefit coverage • Is not married or separated from any other person	• Medical • Dental • Vision • Dependent Same-Sex Domestic Partner Life Insurance	• Notarized Affidavit of Domestic Partnership • Two proofs of joint ownership or joint residency issued within last 6 months
Dependent Child	**Child related to a covered employee up to age 26 including:** • Biological child • Adopted child • Step child • Legal Ward • Child which employee or spouse of employee is legal guardian • Child(ren) may be married, do not have to reside with parents, or be financially dependent upon them, and may be eligible to enroll in their employer's plan.	• Medical • Dental • Vision • Dependent Child Life Insurance	• State issued birth certificate • Adoption certificate • Court ordered document of legal custody
Dependent Child (Same-Sex Domestic Partner)	**Domestic Partner Child up to age 26 with relationship to a covered employee:** • The child of the employee's covered Same-Sex Domestic Partner: • Biological, adopted or legal ward	• Medical • Dental • Vision • Dependent Child Life Insurance	• Required documentation for Same-Sex Domestic Partnership • State issued birth certificate • Adoption certificate • Court ordered document of legal custody

QUALIFIED CHANGE IN STATUS

EXPERIENCE A QUALIFIED CHANGE IN STATUS? CONTACT HUMAN RESOURCES

When a life-changing event (qualified change in status) occurs, you may make a mid-year benefit enrollment change to your current coverage without waiting until the annual employee benefits Open Enrollment period. You must notify Human Resources within 31 days of the event to make a change to your coverage by completing a Request for Qualifying Change in Status form along with providing any required documentation.

Generally, the following change in status events qualify to make a mid-year enrollment change:

- marriage or divorce
- birth or adoption of a child
- death of a dependent
- change in spouse's employment status resulting in a loss of coverage or acquiring new coverage
- loss of dependent's eligibility

Obtaining coverage through the ACA Health Insurance Marketplace qualifies as a mid-year change in status permitting you to make a change to your CSU medical coverage outside of CSU's annual employee benefits open enrollment period.

For more information, see FAQs on Benefits Enrollment on the Human Resources website of myCSU under Benefits.

VIKEHEALTH & WELL-BEING

Vike Health & Well-Being

Get Well. Stay Well. Live Well.

YOUR HEALTH IS IMPORTANT. TAKE ACTION TO GET OR STAY HEALTHY.

ENROLL EACH JULY 1 IN THE VIKEHEALTH AND WELL-BEING PROGRAM

JOIN VIKEHEALTH & WELL-BEING

Each year, starting July 1, you are encouraged to join or re-enroll in CSU's award-winning VikeHealth & Well-Being program to improve and/or maintain your health and well-being and qualify for VikeHealth rewards.

At Cleveland State University, we believe that your health and well-being are important priorities because they help you enjoy a better quality of life — at work, at home and long-term in retirement.

Striving to engage in a healthy lifestyle and get or stay healthy is essential to be able to enjoy what is important to you now and in the future. It is also important to maintaining high-quality health plans at a low cost for you and your family. Our health plan costs and the contributions that we (faculty and staff) pay for coverage are determined based on the claims experience of those covered by the plan. The more we take care of ourselves and maintain our overall health and well-being, the better chance we have of maintaining high-quality, low-cost plans.

The VikeHealth & Well-Being program provides a wide range of free resources, services and support intended to help you improve and maintain your health and well-being including, but not limited to:

- Chronic Condition Management Programs — helps those with Asthma, Chronic Obstructive Pulmonary Disease (COPD), Congestive Heart Failure, Coronary Artery Disease and Diabetes
- Living Well During Your Pregnancy program
- WW® (formerly Weight Watchers) Discount Program
- Health and well-being coaching
- Preventive Health Screenings
- Impact Solutions Employee Assistance Plan
- Tobacco cessation coaching and medications
- Health and well-being education, and
- Health challenges that motivate, educate and make it fun

We encourage you and your family and colleagues to use the resources and participate in VikeHealth & Well-Being to Get Well, Be Well & Live Well — **together!** Go to "VikeHealth & Well-Being" on myCSU to get started.

MEDICAL PLANS

Medical Plan Provisions and Premium Contributions Are Changing July 1, 2020

Premium contributions and plan designs are listed on the comparison chart on pages 6-7.

SPECIAL NOTE:
A listing of helpful definitions is available at ***csuohio.us/2TgmO0W***

Medical Plan Choices

Cleveland State University will offer eligible faculty and staff four medical plan options during the plan year from July 1, 2020 through June 30, 2021.

1. **Medical Mutual (MMO) Traditional Plan** SuperMed Preferred Provider (PPO) Network
2. **Medical Mutual (MMO) Value Plan** SuperMed Preferred Provider (PPO) Network
3. **MetroHealth Select** Exclusive Provider Organization (EPO) (also known as the SkyCare Plan by MetroHealth)
4. **Taxable Cash Option** Waive Medical Coverage (requires proof of coverage)

Selecting a Medical Plan

When selecting a health plan, faculty and staff should consider more than the lowest premium cost. Consideration should be given as to which plan will provide the highest level of benefits at the lowest out-of-pocket expense to meet your medical needs and the network of medical providers of care for you and your family—doctors, hospitals and other ancillary services.

Note: The benefit period for all CSU medical plans is a calendar year (January 1 through December 31). Deductibles, co-insurance maximum and maximum out of pocket accumulators start over January 1.

TRADITIONAL PLAN AND VALUE PLAN – MEDICAL MUTUAL SUPERMED PPO

The Traditional and Value Plans are a Preferred Provider Organization (PPO) through Medical Mutual of Ohio (MMO), which provides three "tiers" or levels of benefit coverage based on medical services and the providers of care:

TIER 1 CSU On-Campus Health and Wellness Services Provider
For limited covered services received from CSU Health and Wellness Services Clinic. Limited services are available with no deductible, co-insurance or co-payment. A claim will be filed with Medical Mutual for payment of services for faculty, staff and dependents who are CSU students.

TIER 2 SuperMed Plus Preferred Provider (PPO) Network (Contracting Provider)
For Covered Services received from a PPO Network Provider, services are subject to deductible, co-payments and co-insurance.

TIER 3 Out-of-Network Provider (Non-Contracting Provider)
For Covered Services received from a Non-PPO Network or Non-Contracting Provider, services are subject to higher deductibles, co-payments and co-insurance.

Medical Mutual serves as the claims administrator paying benefits for services provided by PPO network providers, non-network providers and CSU's On-Campus Health and Wellness Services Clinic. Refer to the medical plans comparison chart on pages 6-7 for CSU employees' share of cost for covered medical services.

To receive the highest level of benefits at the lowest out-of-pocket expense, use the Tier 1 On-Campus Health and Wellness Services Provider and/or Tier 2 SuperMed Plus PPO Network Provider. To locate a Tier 2 SuperMed PPO network provider, search online at www.medmutual.com or call MMO Customer Service at (800) 774-5284 for assistance.

MMO Traditional and Value PPO Plan Changes effective July 1, 2020

To offset rising medical plan costs, changes were made to all three medical plans. For the two PPO plans, the following changes are effective July 1:

- Deductibles, coinsurance maximums and maximum out-of-pocket limits have increased as have copayments for physician office visits, convenience care clinics, urgent care centers and Emergency Room as shown in the charts on pages 6-7.
- Prescription drug copayments have increased as shown on page 9.

METROHEALTH SELECT EXCLUSIVE PROVIDER ORGANIZATION (EPO) – IN-NETWORK COVERAGE ONLY

The MetroHealth Select Plan Exclusive Provider Organization (EPO) through the MetroHealth Hospital System provides over 25 health centers located throughout Cuyahoga County. Covered services must be provided by MetroHealth Select network providers at health center locations. A listing of common services covered under the plan are included in the medical plan comparison chart on
page 7.

Prescription Drug coverage is included as part of the MetroHealth Select plan. Refer to pages 8-10 for more details.
Medical Mutual of Ohio (MMO) is the claims administrator for the MetroHealth Select Plan. MMO reviews and pays claims for covered services provided by MetroHealth Select Network Providers. Questions regarding covered services, claims and requests for identification
cards should be directed to Customer Service at Medical Mutual at (800) 774-5284. Call the MetroHealth concierge line at (216) 778-8818 to schedule appointments, locate network doctors and get information on the services provided at health center locations or visit www.metrohealth.org/select.

MetroHealth Select Plan Changes effective July 1, 2020

To offset rising medical plan costs, the following changes are effective July 1:

- Deductibles, coinsurance maximums and maximum out-of-pocket limits have increased as have copayments for physician office visits, convenience care clinics, urgent care centers and Emergency Room as shown in the charts on pages 6-7. Prescription drug copayments have increased as shown on page 9.

- MetroHealth Select is also known by MetroHealth as the SkyCare plan. Effective July 1, 2020, MetroHealth **will expand the provider network** for CSU plan participants by adding the Lake Health System to the SkyCare network. Lake Health has more than 400 health care providers, primarily in Lake County, who provide a wide range of primary and specialty care. MH Select/ SkyCare members can visit any of the 13 Lake Health locations, 3 acute care hospitals, 7 outpatient centers and 3 urgent care centers.

- In addition, Lumina Imaging and Diagnostics has been added to the MetroHealth Select/SkyCare network. Lumina offers CT scans and MRIs at a significantly lower cost — 50% to 70% less when compared to major hospital systems. Their first location is open in Mentor with additional locations opening in Solon, Avon and Medina during 2020.

CSU HEALTH AND WELLNESS SERVICES - ON-CAMPUS CLINIC

The convenience of low/no-cost on-campus health care for faculty and staff is available at CSU Health and Wellness Services, located in the Center for Innovation and Medical Professions (IM), Room 205. Call (216) 687-3649 for an appointment. Faculty and staff enrolled in the MMO Traditional PPO, Value PPO or MetroHealth Select plans can receive office visit care with coverage as shown in the “Tier 1” column on the medical and prescription drug charts on pages 7 and 9.

TAXABLE CASH OPTION DETAILS

The Taxable Cash Option is available to eligible full-time and part-time faculty and staff electing to waive health care coverage at CSU and receive an annual lump-sum payment in-lieu of enrolling in a medical plan. To receive the payment in their taxable gross earnings at the end of the plan year, employees must provide proof of coverage from a source outside of CSU and select the Cash Option as their medical plan enrollment. The payment is $1,200 for full-time employees, $900 for part-time employees scheduled 30-39 hours if enrolled the entire plan year (July 1 – June 30), or a prorated payment if enrolled a portion of the plan year. Generally, payment is made at the end of the plan year as part of the first paycheck in June.

MEDICAL BENEFITS COMPARISON CHART 2020-21

Your Monthly Premium Contributions

Plan Name	MMO[4] Traditional PPO In-Network	MMO[4] Traditional Out-of-Network	MMO[4] Value PPO In-Network	MMO[4] Value Out-of-Network	CSU Health & Wellness Services (Faculty and Staff Only)	MetroHealth Select EPO In-Network
MMO Tier	TIER 2	TIER 3	TIER 2	TIER 3	TIER 1	
Full-time Faculty/Staff	Single $135.86 Family $354.26		Single $86.62 Family $226.02		n/a n/a	Single $31.70 Family $82.86
Part-time Staff (30-39 hours)	Single $161.98 Family $422.42		Single $144.38 Family $376.74		If you are enrolled in MMO or MetroHealth plans, you can receive certain health services at no cost at CSU Health & Wellness Services as described below.	Single $101.00 Family $347.74
	NOTE: IRS rules require that the payroll premium for same-sex domestic partner's coverage is contributed by employee after-tax and that the value of any benefits provided to a same-sex domestic partner is taxable to the employee.					
Benefit Period	Calendar Year (January 1 - December 31)					

Your Share of Costs

Annual Deductible (A) (Calendar Year)	$600/Single $1,200/Family (Covered preventive care services are NOT subject to deductible)	$1,200/Single $2,400/Family	$1,100/Single $2,200/Family (Covered preventive care services are NOT subject to deductible)	$2,200/Single $4,400/Family	n/a	$350/Single $700/Family (Covered preventive care services are NOT subject to deductible)
Co-Insurance	10%	30%	20%	40%	n/a	10%
Co-Insurance Maximum (B) Calendar Year (Excludes co-payments and deductible)	$1,750/Single $3,500/Family	$3,500/Single $7,000/Family	$3,250/Single $6,500/Family	$6,500/Single $13,000/Family	n/a	$1,000/Single $2,000/Family

Calendar Year 2020 – In-Network Maximum Out-of-Pocket Limits: $8,150 Single $16,300 Family

(out of network claims do not apply)

To comply with Health Care Reform requirements, medical expenses including prescription drugs will be accumulated toward the new maximum out-of-pocket limit. Following is an illustration by plan of the annual limits and how you might meet the maximums.

		In-Network Only Deductibles (A) +	In-Network Only Co-Insurance (B) +	In-Network Only Medical and Prescription Drugs Co-Payments (C) =	In-Network Only Maximum Out-of-Pocket (D)
MMO Traditional	Single	$600	$1,750	$5,800	$8,150
	Family	$1,200	$3,500	$11,600	$16,300
MMO Value	Single	$1,100	$3,250	$3,800	$8,150
	Family	$2,200	$6,500	$7,600	$16,300
MetroHealth	Single	$350	$1,000	$6,800	$8,150
	Family	$700	$2,000	$13,600	$16,300

MEDICAL BENEFITS COMPARISON CHART 2020-21

Plan Name	MMO[4] Traditional PPO In-Network	MMO[4] Traditional Out-of-Network	MMO[4] Value PPO In-Network	MMO[4] Value Out-of-Network	CSU Health & Wellness Services (Faculty and Staff Only)	MetroHealth Select EPO In-Network
MMO Tier	**TIER 2**	**TIER 3**	**TIER 2**	**TIER 3**	**TIER 1**	
Maximum Out-of-Pocket (includes in-network co-payments, co-insurance and deductible)	**2020 Calendar Year Maximum Out-of-Pocket $8,150 Single / $16,300 Family D = In-network Deductibles A + In-network Co-insurance B + In-network Medical & Prescription Drug Co-payments C** (REFER TO CHART ON PAGE 6)					
Primary Care Physician Office Visit C	$35 co-payment	30%[2] co-insurance after deductible	$45 co-payment	40%[2] co-insurance after deductible	No Cost	$25 co-payment
Specialist Office Visit	$40 co-payment	30%[2] co-insurance after deductible	$50 co-payment	40%[2] co-insurance after deductible	Not Available	$25 co-payment
Express Care Online	$35 co-payment	n/a	$45 co-payment	n/a	Not Available	Not Available
Routine, Preventive & Wellness Services C	No Cost[3]	30%[2] co-insurance	No Cost[3]	40%[2] co-insurance	Limited services at no cost	No Cost[3]
Laboratory & Diagnostic Services B	10% co-insurance after deductible	30%[2] co-insurance after deductible	20% co-insurance after deductible	40%[2] co-insurance after deductible	Limited services at no cost	10% co-insurance after deductible
Convenience Care Clinic C	$35 co-payment	30%[2] co-insurance after deductible	$45 co-payment	40%[2] co-insurance after deductible	Services Not Available	Services Not Available
Urgent Care Office Visit C	$50 co-payment	30%[2] co-insurance after deductible	$65 co-payment	40%[2] co-insurance after deductible	Limited services at no cost	$30 co-payment in-network only
Inpatient Medical & Surgical Hospital Services B	10% co-insurance after deductible	30%[2] co-insurance after deductible	20% co-insurance after deductible	40%[2] co-insurance after deductible	Services Not Available	10% co-insurance after deductible
Outpatient Medical, Surgical & Hospital Services C	10% co-insurance after deductible	30%[2] co-insurance after deductible	20% co-insurance after deductible	40%[2] co-insurance after deductible	Limited services at no cost	10% co-insurance after deductible
Institutional Charge for use of Emergency Room B C						
Emergency	10% co-insurance after $300 co-payment (co-payment waived if admitted)	10%[2] co-insurance after $300 co-payment (co-payment waived if admitted)	20% co-insurance after $350 co-payment (co-payment waived if admitted)	20%[2] co-insurance after $350 co-payment (co-payment waived if admitted)	Services Not Available	No Cost after $250 co-payment including out-of-network services (co-payment waived if admitted)
Non-Emergency	10% co-insurance after $300 co-payment (co-payment waived if admitted)	30%[2] co-insurance after $300 co-payment (co-payment waived if admitted)	20% co-insurance after $350 co-payment (co-payment waived if admitted)	40%[2] co-insurance after $350 co-payment (co-payment waived if admitted)	Services Not Available	10% after $250 co-payment. In-network services only (co-payment waived if admitted)
Emergency Room Physician Charges/ Emergency Services B C	10% co-insurance	10%[2] co-insurance	20% co-insurance	20%[2] co-insurance	Services Not Available	10% co-insurance including out of network services
Non-Emergency	10% co-insurance after deductible	30%[2] co-insurance after deductible	20% co-insurance after deductible	40%[2] co-insurance after deductible	Services Not Available	10% co-insurance after deductible in-network services only

[2] Allowed charges for non-network physicians or other professional providers are limited to the lesser of billed charges or the traditional amount. For non-contracting institutional providers, the non-contracting amount applies; non-contracting providers can balance bill.

[3] Evidence-based items or services that have a rating of (A) or (B) in effect in the current recommendation of the United States Preventive Services Task Force.

[4] Pre-authorization by MMO may be required for some services (e.g. surgical procedures, diagnostic tests, MRIs and scans) for which you are financially responsible. Refer to your plan certificate for details.

Denotes services may be eligible for VikeHealth & Well-Being points.

PRESCRIPTION DRUG COVERAGE

Prescription drug coverage is included as part of the medical plan you choose. Your medical ID card also serves as your prescription drug card. Prescription drug coverage for all medical plans is administered by Medical Mutual, Express Scripts®.

The chart located on page 9 summarizes the prescription drug cost share (co-payments and co-insurance) by medical plan. This chart is intended to help you understand the cost impact to you when you utilize prescription drug coverage.

Prescription drug coverage under all three medical plans includes the prescription drug cost management program. The following is a list of the programs:

- Specialty Prescription Drugs
- Prior Authorization for certain prescriptions
- Quantity Limit
- Preferred Drug Step Therapy
- Exclusion of Compound Medications
- RationalMed Drug Safety Program

More details of the prescription drug cost management program are described on pages 9-10 of this booklet. Information is also located on Medical Mutual's website at www.medmutual.com.

MEDICAL MUTUAL TRADITIONAL AND VALUE PPO PRESCRIPTION COVERAGE

Medical Mutual (MMO) provides access to its Retail and Home Delivery Pharmacy Network through Express Scripts®. Members can get prescriptions filled up to a 30-day supply at a network retail pharmacy and/or use the Express Scripts® Home Delivery Pharmacy services to fill prescriptions for a 90-day supply of maintenance medications for the retail cost of two-months co-payments. Contact Express Scripts® at (800) 282-2881 or online at www.express-scripts.com to locate a network retail pharmacy or for details as to how to use mail order pharmacy services.

Specialty prescription drugs are included within the Prescription Cost Management Program. It is important to note that prescriptions for specialty medications must be filled through the Medical Mutual Specialty Drug Solution—Accredo Specialty Pharmacy or Gentry Health Services. Accredo Specialty Pharmacy and Gentry Health Services are the sole sources for direct delivery of specialty medications. The cost of prescriptions for specialty medications filled at any other pharmacy will be the responsibility of the participant. Refer to pages 9-10 for a description of the program.

METROHEALTH SELECT EPO PRESCRIPTION COVERAGE

MetroHealth has onsite pharmacies as part of at least nine (9) health center locations with two more coming soon. The MetroHealth plan provides prescription drug benefits for up to a 30-day supply of medication and a 90-day supply (retail or home delivery) of maintenance medication to control chronic health conditions. Co-payments are the lowest when members use a MetroHealth pharmacy. Call (216) 957-MEDS (6337) for all pharmacy needs, or go online to www.metrohealth.org/ pharmacy for more information.

MetroHealth Select participants also have access to Medical Mutual Retail and Home Delivery Pharmacy Network through Express Scripts. Members can have prescriptions filled up to a 30-day supply at a network retail pharmacy and/or use the Express Scripts Home Delivery Pharmacy services to fill prescriptions for a 90-day supply of maintenance medications at an increased co-payment cost.

The medical plans through CSU include a Prescription Cost Management Program. Refer to pages 9-10 for more details. Specialty prescription drugs are included within the Prescription Cost Management Program. MetroHealth participants have access to the two providers from Medical Mutual for specialty medications—Accredo Specialty Pharmacy or Gentry Health Services. It is important to note that prescriptions for specialty medications must be filled through the Accredo Specialty Pharmacy, or Gentry Health Services. Accredo Specialty Pharmacy and Gentry Health Services are the sole sources for direct delivery of specialty medications. The cost of prescriptions for specialty medications filled at any other pharmacy will be the responsibility of the participant. Refer to pages 9-10 for a description of the program.

PRESCRIPTION DRUG COST SHARE PLAN COMPARISON CHART 2020-21 Your Cost Share of Coverage						
	MMO Traditional PPO Express Scripts Network Pharmacy TIER 2	**MMO Traditional Out-of-Network TIER 3**	**MMO Value PPO Express Scripts Network Pharmacy TIER 2**	**MMO Value Out-of-Network TIER 3**	**CSU Health and Wellness Services TIER 1**	**MetroHealth Select EPO Network** (out of network covered services not provided) (Administered by MMO)[2]
Non-Maintenance Retail Pharmacy Prescription Drugs (30-day Supply) • Mandatory Generic • Non-specialty • Mandatory Mail order for maintenance medications Co-payments and Co-insurance are per prescription	Co-payment: Generic $10 Brand: Formulary $40 Brand: Non-formulary $75 Co-payment for maintenance medications doubles after three fills at a retail pharmacy	25% of allowed amount[3], plus co-payment, plus excess cost Claim form required for reimbursement	Co-payment: Generic $15 Brand: Formulary $50 Brand: Non-formulary $95 Mandatory Mail Order co-payment for maintenance medications doubles after three fills at a retail pharmacy	25% of allowed amount[3], plus co-payment, plus excess cost Claim form required for reimbursement	Co-payment: Generally $5 Limited prescriptions available	Co-payment: MetroHealth[1] / MMO[2] Generic $0 / $10 Brand: Formulary $30 / $45 Brand: Non-formulary $60 / $90
Pharmacy Mail Order Non-Specialty (90-day Supply) • Mail order required for maintenance • Mandatory generic Co-payments are per prescription	Co-payment: Generic $20 Brand: Formulary $80 Brand: Non-formulary $150	Not Covered	Co-payment: Generic $30 Brand: Formulary $100 Brand: Non-formulary $190	Not Covered	Service Not Available	Co-payment: MetroHealth[1] / MMO[2] Generic $10 / $20 Brand: Formulary $60 / $90 Brand: Non-formulary $120 / $180
Specialty Prescription Drugs Must use Accredo Specialty Pharmacy	10% co-insurance up to $175 max. per prescription	Not Covered	10% co-insurance up to $200 max. per prescription	Not Covered	Service not available	No co-insurance Retail co-payment applies

[1] MetroHealth Select Plan members pay lower co-pays when using MetroHealth pharmacies. Use an on-site MetroHealth pharmacy for a 30-day supply of any medication, or a 90-day supply of maintenance medications. You may also use the MetroHealth Mail Order service for a 90-day supply of maintenance medications.

[2] MMO/Express Scripts network pharmacies (non-Metro Pharmacy)

[3] MMO out-of-network reimbursements are subject to allowable charges. Refer to your plan certificate for details.

PRESCRIPTION DRUG COST MANAGEMENT PROGRAMS

CSU has prescription drug cost management programs which help to reduce overall plan costs and limit cost-sharing with employees. As a medical plan participant, you may be required to follow program procedures in order for your medication to be covered. This section provides an overview of the programs. Detailed information is located on Medical Mutual's website.

1. **Specialty Drug Solution program** – Specialty drugs are medications that require special handling, administration or monitoring. They are often used to treat rare, complex and chronic conditions. These drugs are usually injected but may be taken by mouth.

Common examples of specialty drugs include, but are not limited to: Enbrel • Viekira • Humira • Betaseron • Copaxone • Growth hormones • Gleevec

When using the Specialty Drug Solution Program, covered participants receive a variety of specialized services including:
- Safe, Prompt Delivery of medications
- Access to personalized care from dedicated nursing and pharmacy staff
- Supplies that accompany certain types of medications
- 24/7 Support Services
- Refill Reminders
- Drug Safety Monitoring
- Help with enrolling in patient assistance programs

Contact either Accredo or Gentry, and they will contact your prescriber for your prescription. Your prescriber can also call in or fax the prescription.

- Accredo Specialty Pharmacy: Phone: (800) 803-2523 Fax: (888) 302-1028
- Gentry Health Services: Phone: (844) 443-6879 Fax: (844) 329-2447

PRESCRIPTION DRUG COVERAGE

2. **Prior Authorization for Prescriptions** – In order for a prescription to be covered, certain prescription drugs will require the covered member to obtain an approval through the coverage review process prior to filling your prescription. To initiate the coverage review process, the member, the member's doctor or pharmacist may call Express Scripts at 1-800-753-2851.

   Express Scripts' "Price a Medication" tool on their website will tell you if a medication is subject to this cost management program. Select "Prescriptions" and then "Price a Medication" from the menu bar. If coverage is approved, members pay the normal co-payment for the medication. If coverage is not approved, the member will be responsible for the full cost of the medication. Note: Members have the right to appeal the decision. Information about the appeal process will be included in the notification letter they receive.

3. **Quantity Limit** – Some prescription drugs will be only covered up to a certain quantity limit per fill. This list generally includes medications that are not taken every day. Getting quantities beyond the predetermined limit requires prior authorization from Express Scripts. Express Scripts' "Price a Medication" tool on their website will tell you if a medication is subject to this cost management program. Select "Prescriptions" and then "Price a Medication" from the menu bar.

4. **Preferred Drug Step Therapy** – CSU medical plan rules require the use of a generic or lower-cost brand-name alternative before use of higher cost non-preferred drugs can be covered by the Plan, unless special circumstances exist. Express Scripts' "Price a Medication" tool on their website will tell you if a medication is subject to this cost management program. Select "Prescriptions" and then "Price a Medication" from the menu bar. Members using one or more of the medications on the list will need to switch to a generic or a preferred brand-name drug. Members who do not switch will pay the full price for their medication.

   Express Scripts will use an automated process to determine if a member qualifies for coverage based on information that Medical Mutual has on file, which includes medical history, drug history, age and gender. If a member's physician believes special circumstances exist, he/she may request a coverage review by calling Express Scripts at 1-800-753-2851.

5. **Compound Medications are excluded from coverage** – Compound medications are made when a licensed pharmacist combines, mixes or alters a medication's ingredients to meet a doctor's request. Compounded medications are not reviewed as final products by the U.S. Food and Drug Administration (FDA), so there is no way for the FDA to confirm their quality, safety and effectiveness. In addition, compound medications often come at an unusually high cost even though alternatives exist at a lower cost. As a result, the Plan will not provide coverage for compounded medications. Covered members wishing to use these medications will be responsible for paying the full cost.

6. **RationalMed Drug Safety Program** – A Medical Mutual/Express Scripts safety program that uses medical and drug claim data to help identify potential safety issues. Checks for adverse drug risks; coordination of care; omission of essential care. It works mainly by alerts being sent to prescribing physicians.

For general prescription drug questions, call Express Scripts Customer Service at (800) 417-1961

MetLife Insurance

Your dental coverage is provided by MetLife's Preferred Dentist Program (PDP). Notify your dentist you are covered by Metlife's PDP Program.

Find a Dental Provider: A list of participating dental providers is located at metlife.com/dental (select PDP Plus network), or you may call customer service at (800) 942-0854.

Dental ID Card: Dental cards will be available for you to download at www.metlife.com/mybenefits. Dental cards will not be mailed to your home. You do not need to present an ID card to confirm your eligibility.

EMPLOYEE MONTHLY DENTAL PRE-TAX PREMIUM	
FULL-TIME FACULTY AND STAFF	Single: $3.18 Single Plus One: $6.22 Family: $10.76
PART-TIME ADMIN. FACULTY AND STAFF 30-39 HOURS	Single: $7.96 Single Plus One: $15.52 Family: $26.88

Access to CSU Dental Plan Information: The website customized for CSU's plan will be available for those enrolled in the dental plan. This will allow you to access your plan of benefits, co-payments, co-insurance and claims information. Visit metlife.com/mybenefits, or contact customer service at (800) 942-0854.

Mobile App: The app is available on the iTunes® App Store and Google Play.

Dental Premium Contributions Will Not Change July 1, 2020; Some Frequencies of Services are Changing

To offset a proposed premium increase, changes are being made to the frequency of coverage for the following dental services. "Prosthetic replacements" includes services such as: crowns, prefabricated crowns, inlays and onlays, bridges, dentures and implants. The change affects how often these services are covered by the plan.

The monthly pre-tax employee share of cost for dental premiums is listed above.

BENEFIT	CURRENT FREQUENCY	NEW FREQUENCY
Bitewing x-rays	1 in 6 months	1 in 1 year
Full mouth x-rays	1 in 3 years	1 in 5 years
Prosthetic Replacements	1 in 5 years	1 in 7 years

DENTAL PLAN SCHEDULE OF COVERAGE		
	In-Network Provider $1,500 Annual Max Per Person **Plan Pays**	**Out-of Network Provider** $1,200 Annual Max Per Person **Plan Pays**[2]
Calendar Year Deductible	$50 per person / $150 maximum per family	$50 per person / $150 maximum per family
DIAGNOSTIC AND PREVENTIVE		
Diagnostic and Preventive Services Exams, cleanings, fluoride, sealants, x-rays and space maintainers	100%	100%[2]
BASIC SERVICES[1]		
Restorative Services Fillings and crowns	80%	80%[2]
Endodontic Services Root canals	80%	80%[2]
Periodontic Services To treat gum disease	80%	80%[2]
Oral Surgery Services Extractions and dental surgery	80%	80%[2]
MAJOR SERVICES[1]		
Prosthodontic Services Bridges, dentures and implants	60%	60%[2]
ORTHODONTIC SERVICES		
Orthodontic Services Braces; No Age Limit, $1200 lifetime maximum per person	60%	60%[2]

DOWNLOAD YOUR ID CARD AT METLIFE.COM/MYBENEFITS

NOTIFY YOUR DENTIST THAT METLIFE IS YOUR INSURANCE COMPANY

SMARTPHONE USERS CAN MANAGE THEIR DENTAL PLAN THROUGH THE METLIFE MOBILE APP

[1]A deductible of $50 per person / $150 per family benefit year maximum applies to "Basic" and "Major" dental services

[2]When you receive services from a out-of-network dentist, the percentages in this column indicate the portion of Metlife'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.

VISION PLANS

Cleveland State University offers two vision plan options through Vision Service Plan (VSP) to choose for vision coverage—the "Basic" Plan and the "Opt-up" Plan.

There will be no changes to plan provisions and no increase in premium July 1, 2020

VSP's preferred provider organization (PPO) network of retail vision providers include Costco Optical, Pearle Vision, Vision Works, SVS Vision and Thomas & Sutton Eye Care. Members can maximize vision benefits through both plans by using VSP's PPO network that offers covered services for eye care examinations, frames and eyeglasses or contacts. To find the nearest location for the new PPO network providers, contact VSP at www.vsp.com or (800) 877-7195.

The Basic Vision Plan provides covered services once in a 24-month period from the date of last service. The "Opt-up" Vision Plan provides covered services once in a 12-month period from the date of last service, including enhanced coverage for tints and photochromic lenses for eyeglasses or "transition" lenses. In addition, each plan allows for limited reimbursement for services provided out-of-network by non-VSP providers; or the member can pay at the point services are received and submit a claim for reimbursement of out-of-pocket cost within six months of receiving services.

LOG IN TO YOUR VSP ACCOUNT AT WWW.VSP.COM TO:

- Choose a VSP network doctor
- Print an ID card
- View your personal eye care coverage
- Find the latest eye health information
- Learn about special discounts and promotions

OR CALL (800) 877-7195

This is your annual opportunity to switch your plan: Basic ➔ Opt-up Opt-up ➔ Basic

EMPLOYEE MONTHLY VISION PRE-TAX PREMIUMS - EFFECTIVE JULY 1, 2020		
	Basic Vision Plan	**Opt-up Vision Plan**
FULL-TIME FACULTY AND STAFF	No premium contributions	Single $5.98 Family $17.06
PART-TIME ADMIN. FACULTY AND STAFF 30-39 HOURS	Single $.94 Family $2.70	Single $6.92 Family $19.76
FREQUENCY OF COVERAGE	24 months from date of last service	12 months from date of last service

VISION SUMMARY OF BENEFITS FOR BASIC AND OPT-UP PLANS		
	In-Network	**Open Access (Out-of-Network) Reimbursement Level**
Vision Exam	100% after $15 Co-pay	Up to $45
Prescription Glasses	$25 Co-pay	n/a
Lenses**	100% Single Vision, lined bi-focal and lined tri-focal lenses Polycarbonate lenses for dependent children.	Single Vision up to $30 Lined Bifocal up to $50 Trifocal up to $65
Lens Options**	Progressive: Covered in Full	Progressive: Up to $50
Frames	Covered up to plan allowance of $150 $80 Costco Allowance	Up to $70
Contact Lenses (instead of glasses)	$150 allowance for contacts and exam, if elective; 100% covered if visually necessary VSP requires proof of visual necessity.	If elective, up to $105; If visually necessary, up to $210 VSP requires proof of visual necessity.
Claims	No claim form required	Must file claim for reimbursement within 6 months from date of service.

* The Opt-up also includes enhanced coverage for lenses for eyeglasses, including coverage for tints and photochromic or "transition" lenses.

** See VSP summary of coverage handout for coverage specifics and limitations for lenses.

FLEXIBLE SPENDING ACCOUNT PLANS

To participate in a FSA for the plan year July 1, 2020-June 30, 2021, you must make an election during the annual Open Enrollment period.

You must re-enroll each plan year to continue participation in a FSA.

Health Care spending limit increases to $2,750.

With changes to the medical and dental plans, you might want to consider a Health Care FSA this year.

The Flexible Spending Account Plan (FSA) allows you to set aside funds through pre-tax payroll deductions for unreimbursed out-of-pocket health care and/or dependent day care expenses (e.g. co-payments, co-insurance and deductibles). Eligible out-of-pocket expenses are defined by the Internal Revenue Service (IRS). You determine how much money you want to contribute up to the FSA plan limits. The amount you select is deducted through payroll and is based on the number of pay periods you have within the CSU plan year (July 1 – June 30). You are reimbursed for eligible expenses from your FSA account as you incur and submit a claim for reimbursement.

FSA Plan Use It or Lose It Rule

The Internal Revenue Service (IRS) requires a "Use It or Lose It" rule for FSA accounts. If expenses are not incurred and/or filed for reimbursement within the allowable time periods, funds remaining in your account are forfeited. You should carefully calculate the amount you contribute to a FSA each plan year.

FSA Debit Card

A FSA debit card (Medical Mutual MasterCard) will be issued to each newly enrolled plan participant. Based on your account balance/election, the debit card will allow you to immediately pay for eligible FSA expenses where debit cards are accepted. **When using your debit card, you should continue to maintain receipts in the event you are asked by FlexSave to submit receipts to substantiate claims. Unsubstantiated claims may cause your card to be suspended or may result in the claim becoming taxable to you.**

Medical Mutual Flexible Spending Accounts Online Account Access

Medical Mutual offers online access to your flexible spending accounts at www.medmutual.com. Participants can view their account, validate debit card swipes, order additional cards, repay non-qualified expenses and have Internet claims entry. Login to Medical Mutual's MyHealth plan to access your account. Go to the "claims and balances" section of MyHealth Plan and select "my spending account" to view your information.

FSA PLAN LIMITS AND ENROLLMENT RULES

CSU offers two types of FSA accounts under the plan–Health Care FSA and a Dependent Day Care FSA.
The plan year limits for each account is a minimum of $24/year.
The maximum amount for a Health Care Spending Account is $2,750. The Dependent Day Care Account limit is $5,000.

To participate in a FSA, you must make an election during the Open Enrollment period, unless you have a qualified change in status which allows for a mid-year election change. (Refer to Qualified Change in Status Rules on the Human Resources Benefits web page of myCSU).

YOU MUST RE-ENROLL EACH PLAN YEAR TO CONTINUE PARTICIPATION IN A FSA. Each time you enroll in a FSA, you should carefully calculate the amount you contribute as contributions are subject to the forfeiture rules described here.

Note: Contributions to a Dependent Day Care account may be further limited based on your marital status, how you file your income taxes and if your spouse works or attends school full-time. Consult your tax advisor as how FSA Dependent Day Care Accounts affect your personal situation.

2020-21 FSA PLAN YEAR DEADLINES	
Payroll Contributions	FSA elections made during the annual Open Enrollment period will be deducted on a pre-tax basis according to your pay periods during July 1, 2020 – June 30, 2021, or through May 15 for faculty paid over nine months.
Plan year period to incur eligible expenses	Participants enrolling for the 2020-21 plan year must incur expenses from July 1, 2020 through September 15, 2021 (which includes a 2½-month grace period).
Claim Filing Deadline	**All eligible claims incurred during the plan year period must be received by Medical Mutual (not postmarked) no later than September 30, 2021.** If you separate/retire from the University, you have 60 calendar days from your separation date for Medical Mutual Flexible Spending Accounts to receive claims which were incurred prior to your last day of employment. Refer to claim filing instructions located on the Human Resources Benefits webpage of myCSU.

DETAILS OF THE CSU FLEXIBLE SPENDING ACCOUNT PLAN ARE AVAILABLE ON THE HUMAN RESOURCES WEBPAGE OF MYCSU, OR CONTACT FLEXSAVE AT (800) 525-9252.

SUPPLEMENTAL LIFE INSURANCE | ADMINISTERED BY SECURIAN FINANCIAL

Annual Open Enrollment Opportunity to Increase Supplemental Employee and Spouse/Same-Sex Domestic Partner Life Insurance Coverage

During Open Enrollment, if you are currently enrolled in the Supplemental Employee and Spouse/Same-Sex Domestic Partner Life Insurance plans, you have an opportunity to increase your Supplemental Life Insurance coverage for yourself by one unit, $10,000 and for your Spouse/Same-Sex Domestic Partner by one unit, $5,000, up to the maximum guaranteed issue limit.

Plan rules apply:

- Supplemental Life Insurance coverage for your Spouse/Same-Sex Domestic Partner cannot exceed 100% of your Employee Supplemental Life Insurance coverage.
- The Maximum Guaranteed Issue limit of coverage without Evidence of Insurability (EOI): Employee — $200,000 Spouse/Same-Sex Domestic Partner — $100,000
- If your decision to purchase a unit of coverage for yourself and/or your Spouse/Same-Sex Domestic Partner results in coverage exceeding the maximum guaranteed issue amount(s), EOI must be submitted to Securian Financial for approval.
- EOI is required for coverage amounts of $210,000 to $500,000 for an employee and $105,000 to $250,000 life insurance coverage for a Spouse or Same-Sex Domestic Partner.

OPEN ENROLLMENT IS A GOOD TIME TO VERIFY AND UPDATE YOUR BENEFICIARIES

You may make changes to your Basic and Supplemental Life Insurance beneficiaries anytime during the year.
Open Enrollment is a good time to verify your information and make changes online.

Cost of coverage increases in the month in which your age reaches a new age-band.

A reduction in employee Supplemental Life coverage may result in a reduction to spouse/same-sex domestic partner coverage if level does not fall within plan rules.

SUPPLEMENTAL LIFE INSURANCE		
MONTHLY RATES PER $1,000 OF COVERAGE		
Age	**Non-Tobacco User**	**Tobacco User**
< 25	$0.031	$ 0.064
25-29	$0.031	$0.064
30-34	$0.037	$0.080
35-39	$0.048	$0.095
40-44	$0.069	$0.138
45-49	$0.113	$0.227
50-54	$0.174	$0.348
55-59	$0.323	$0.646
60-64	$0.392	$0.784
65-69	$0.683	$1.366
70-74	$1.107	$2.214
75 and older	$1.558	$3.117

NOTE: Rates are based on the employee's age and tobacco user status. Monthly premium amount is divided between the first two paychecks of each month.

MEDICAL PLANS

Medical Mutual of Ohio - Traditional Plan (Plan #961056-017) and Value Plan (Plan #961056-018)

NETWORK, PLAN, CLAIMS & ID CARD QUESTIONS (800) 774-5284
24/7 NURSE LINE (888) 912-0636
WEBSITE www.medmutual.com
EXPRESS SCRIPTS (PRESCRIPTION DRUG) (800) 282-2881
WEBSITE www.express-scripts.com

Accredo Specialty Pharmacy

PHONE (800) 803-2523

MetroHealth Select (administered by Medical Mutual) (Plan #961056-201)

FOR APPOINTMENTS ONLY CALL (216) 778·8818
Contact Medical Mutual for
NETWORK, CLAIMS & ID CARD QUESTIONS (800) 774-5284
24/7 NURSE LINE (888) 912-0636
WEBSITE (LOCATIONS, DOCTORS, MYCHART) www.metrohealth.org/select

CSU Health and Wellness Services On-Campus Clinic for Faculty/Staff/Students *Visits by appointment only.*

CAMPUS LOCATION Center for Innovations in Medical Professions, Rm 205
PHONE (216) 687-3649
EMAIL healthandwellness@csuohio.edu

DENTAL PLAN

MetLife (Plan #214794)

CUSTOMER SERVICE (800) 942-0854
WEBSITE www.metlife.com/dental (provider search - Select PDP Plus network)
www.metlife.com/mybenefits

VISION PLANS - BASIC & ENHANCED (OPT-UP)

Vision Service Plan (VSP)

NETWORK, PLAN AND CLAIMS QUESTIONS (800) 877-7195
WEBSITE www.vsp.com

FLEXIBLE SPENDING ACCOUNTS

Medical Mutual Flexible Spending Health Care and Dependent Day Care Accounts

CUSTOMER SERVICE (800) 525-9252
WEBSITE www.medmutual.com *(Go to claims and balances, My spending accounts)*

FACULTY AND STAFF WELLNESS

VikeHealth & Well-Being Program

CAMPUS LOCATION Parker Hannifin Administration Center, Rm 113
WEBSITE https://mycsu.csuohio.edu (Click on VikeHealth & Well-Being)
MANAGER, VIKEHEALTH & WELL·BEING (216) 687·3760
EMAIL l.m.sandor@csuohio.edu

FAMILY MEDICAL LEAVE

Sedgwick

PHONE (888) 436-9530
EMPLOYEE LEAVE REPORTING/REVIEW PORTAL www.timeoff.sedgwick.com

WORKER'S COMPENSATION

CareWorks (A Sedgwick Company) (First Report of Injury)

PHONE (888) 627-7586, Option 1
WEBSITE www.froi.careworksmco.com

BENEFITS QUICK REFERENCE

EMPLOYEE ASSISTANCE PROGRAM

IMPACT

PHONE (800) 227-6007
WEBSITE www.impactemployeeassistance.com
Username: csu

LIFE INSURANCE

Securian Financial (formerly Minnesota Life)

CUSTOMER SERVICE CONTACT CENTER (866) 293-6047
Hours 8:00 a.m.-7:00 p.m.: Monday-Friday. ET

LONG TERM DISABILITY INSURANCE

UNUM

CUSTOMER CONTACT CENTER (800) 858-6843
Hours 8:00 a.m.-8:00 p.m.: Monday-Friday. ET
POLICY NUMBER 604607

VOLUNTARY INSURANCE BENEFITS

UNUM Individual Short-Term Disability Insurance
UNUM Accident Insurance

CUSTOMER SERVICE FOR QUESTIONS OR CHANGES TO EXISTING POLICIES (800) 635-5597
WEBSITE www.unum.com

TRAVEL ASSISTANCE PROGRAMS

The Hartford - Europ Assistance USA

TRAVEL ASSISTANCE ID. GLD·09012
POLICY NUMBER FOR MEDICAL SERVICES (ETB 141026) -
For serious medical emergency. please obtain medical services first then contact Europ Assistance
INSIDE U.S./CANADA (888) 286-3802 I (240) 330-1518
(Collect calls accepted from other locations)
WEBSITE thehartford.com/employeebenefits

Securian Financial
Redpoint Resolutions Travel Assistance Services

INSIDE U.S/CANADA (855) 516-5433
OUTSIDE U.S. 001-1-415-484-4677
WEBSITE www.redpointresolutions.com

UNUM Worldwide Emergency Travel Assistance - Available 24/7

REFERENCE NUMBER: 01-AA-UN-762490 at www.assistamerica.com
INSIDE U.S. (800) 872-1414
OUTSIDE U.S. (collect calls accepted) 001-609-986-1234
EMAIL medservices@assistamerica.com

RETIREMENT PLANS

Ohio Public Employees Retirement System (OPERS)

PHONE (800) 222-7377
WEBSITE www.opers.org

State Teachers Retirement System (STRS)

PHONE (888) 227-7877
WEBSITE www.strsoh.org

457 PLAN

Ohio Deferred Compensation Program

PHONE (877) 644-6457
WEBSITE www.ohio457.org

ALTERNATIVE 401A RETIREMENT PLAN (ARP)/SUPPLEMENTAL403B SAVINGS PLAN

Vendors and contact information for these plans are located on the Human Resources Benefits webpage of myCSU.

WOMEN'S HEALTH AND CANCER RIGHTS ACT OF 1998

The Women's Health and Cancer Rights Act (WHCRA) of 1998 provides benefits for individuals who have had or elect to have a mastectomy. For individuals receiving mastectomy-related benefit coverage will be provided in the manner determined in consultation with the attending physician and the patient for:

- All stages for reconstruction of the breast on which the mastectomy was performed;
- Reconstructive surgery of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of all stages of mastectomy, including lymphedema (swelling associated with removal of the lymph nodes).

These benefits will be provided subject to the same deductibles and co-insurance applicable to other medical and surgical benefits provided under the medical plans. Therefore, the deductibles and co-insurance will apply according to the charts on pages 6-9 of this booklet and certificate of coverage from your medical plan provider. If you would like more information on WHCRA benefits, contact your medical plan administrator at the phone numbers listed on your medical card or on the benefit directory included in this booklet.

CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT (COBRA)

Under certain circumstances, you and/or your covered spouse or dependent children may continue your health care coverage after your employment with Cleveland State University has ended. This is called COBRA coverage, under the Consolidated Omnibus Budget Reconciliation Act.

If you are eligible to continue coverage under COBRA, you will receive information and an election form from Cleveland State University's (CSU's) administrator, Chard-Snyder outlining your benefit options, costs and any deadlines associated with election and/or paying for coverage.

When an employee and any covered dependents lose coverage due to termination of employment with CSU, COBRA benefits are available for up to 18 months. If a covered spouse or dependent loses eligibility resulting in a loss of coverage (and not the employee), COBRA benefits are available for up to 36 months.

Continuation of a health care flexible spending account under COBRA will only be offered when the available balance in the account is more than the cost of the COBRA premiums. A health care flexible spending account is only available under COBRA through the end of the current plan year.

Individuals who elect continuation coverage are required to pay the full cost of the coverage, plus a 2% administrative charge.

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 (HIPAA)

Special Enrollment Periods

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) provides rights and protections for participants in group health plans. Under HIPAA, if you waive or drop coverage for yourself and/or your covered dependents because of other health insurance coverage, and you and/or your covered dependents lose coverage for that plan, you may be able to enroll yourself and your eligible dependents in a CSU health plan. To do so, you must request enrollment and notify the CSU Department of Human Resources within 31 calendar days of the loss of coverage.

In addition, if you are not enrolled in a CSU sponsored health plan and you acquire a newly eligible dependent as a result of marriage, birth, placement for adoption or obtaining legal guardianship, you may be able to enroll yourself and your eligible dependents. Again, you must request enrollment and notify the CSU Department of Human Resources at (216) 687-3636 within 31 calendar days following the event.

How We Use and Protect Your Health Information

In the process of administering your benefits, we sometimes access Protected Health Information (PHI) that belongs to you, your spouse/same-sex domestic partner and/or your dependents for a variety of reasons, including, but not limited to, administering claims and determining health plan premiums. The way we can use PHI is regulated under a federal law known as the Health Insurance Portability and Accountability Act (HIPAA). Recently, HIPAA was amended to provide further restrictions on how PHI can be used along with certain notice requirements following a breach of unsecured PHI. In general, these changes are reflected in our Privacy Notice, which can be found on the Human Resources webpage of myCSU in the Policies and Procedures section. You can request a paper copy of this revised Privacy Notice by contacting Human Resources at (216) 687-3636.

CLEVELAND STATE UNIVERSITY

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