



Cuyahoga Community College's
Flexible Benefits Plan

2026

BENEFITS GUIDE

Cuyahoga
Community
College



Welcome to Cuyahoga Community College (Tri-C®) — Where Futures BeginSM

Dear Valued Colleagues,

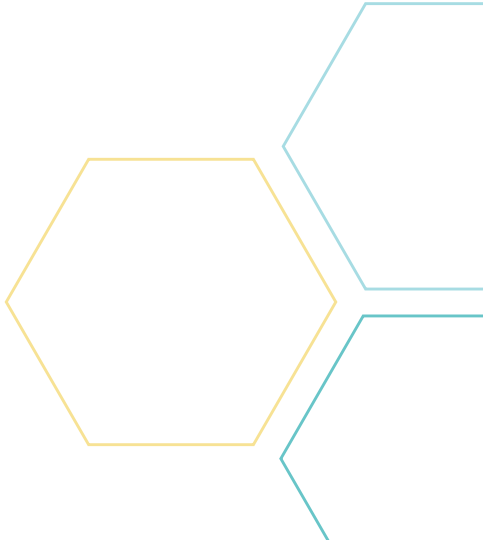
We are excited to present this comprehensive overview of your benefits options. This guide provides you with essential information to make informed decisions about your benefits package. As a new employee exploring your options for the first time, this guide is here to help you navigate the process. Read on to discover the array of benefits available to you.





See What's Inside

- How To Enroll in Benefits..... 2
- Eligibility 2
- Medical, Dental and Vision Plan Rates at a Glance..... 3
- Medical and Prescription Drug Plans 4
- Health Savings Account (HSA)..... 6
- Delta Dental 7
- Vision Plan Options 8
- Flexible Spending Accounts..... 9
- Health and Well-Being..... 10
- Disability Benefits 11
- Life Insurance Coverage 12
- Aetna Supplemental Plans 14
- Employee Assistance Program (EAP)..... 16
- Remission of Fees..... 16
- Tuition Reimbursement for Non-Bargaining Employees..... 16
- Your Retirement Benefits 17
- Voluntary Retirement Savings Plans..... 20
- Paid Time Leave..... 21
- Provider Contact Information..... 24
- Your Benefits Team..... 24
- Legal Notices and Rights..... 25



How To Enroll in Benefits

Step 1: Attend your scheduled New Hire Benefits presentation.

Step 2: Use this guide as a resource to answer your questions, and check the [Benefits KWeb page](#) for additional information about each benefit plan.

Step 3: Enroll online through *my Tri-C space* > Select the “Open Employee Dashboard” on the Employee Self-Service card > Benefits > Employee Benefits > BenefitPlace.

Your benefits are effective the first day of the month following your date of hire. If your date of hire is the first working day of the month, then your benefits will be effective on your hire date.

Eligibility

All full-time employees are eligible to enroll in Tri-C’s flexible benefits plan. Your enrollment elections become effective on the first day of the month following your date of hire.

Eligible Dependents

Spouse	Not eligible for coverage under the College medical plan if they have access to medical coverage under their own employer
Domestic Partner	
Children	Under age 26
	Natural children, stepchildren, legally adopted children
	Your domestic partner's biological or legally adopted child(ren)
	Children who, by court order, must be provided health care coverage by you and/or your spouse or domestic partner
Legal Guardianship	Children for whom you, your spouse or domestic partner are the legal guardian or custodian
Disabled Dependent	Adult children older than the usual eligibility age who have a physical or mental handicap that prevents self-support
	Medical certification required

**Employees not part of the Service Employees International Union (SEIU) who have been continuously employed in a full-time position since Dec. 31, 2019, and employees part of SEIU who have been continuously employed in a full-time position since Dec. 31, 2020, are exempt from this rule.*

Domestic Partnership

To be considered eligible for coverage, your domestic partner must meet the following requirements:

- At least 18 years old
- Not legally married to another person
- Not related by blood to a degree of closeness that would prohibit marriage
- In an exclusive, committed relationship that is intended to be permanent
- Mutual obligation of support and responsibility for each other’s common welfare
- Has shared a principal residence with you for at least six months and intends to do so permanently

Supporting Documentation

You are required to submit supporting documentation for all new dependents before coverage can be approved and applied. After submitting your benefit elections, you will receive an email detailing the necessary documents. Please upload these documents through Benefitplace.

Medical, Dental and Vision Plan Rates At A Glance

Biweekly costs are shown below. Once you enroll in a plan, your cost will be automatically deducted from each paycheck on a pre-tax basis (before federal, state, local and Medicare taxes).



Medical

Faculty Rates

COVERAGE LEVEL	MEDICAL MUTUAL BIWEEKLY EMPLOYEE COST <i>Based on 22 Pay Periods</i>	
	Preferred Choice (PPO)	Healthy Saver Plan
Single	\$114.44	\$92.98
Employee + 1 Dependent	\$248.50	\$199.56
Family	\$342.06	\$264.43

Non-Faculty and Lecturer Rates

COVERAGE LEVEL	MEDICAL MUTUAL BIWEEKLY EMPLOYEE COST <i>Based on 26 Pay Periods</i>	
	Preferred Choice (PPO)	Healthy Saver Plan
Single	\$96.83	\$78.67
Employee + 1 Dependent	\$210.27	\$168.86
Family	\$289.43	\$223.75

Dental Plan

COVERAGE LEVEL	DELTA DENTAL BIWEEKLY EMPLOYEE COST	
	Faculty 22 Pay Periods	Non-Faculty 26 Pay Periods
Single	\$16.83	\$14.24
Employee + 1 Dependent	\$32.22	\$27.26
Family	\$62.97	\$53.28

Vision Plan

COVERAGE LEVEL	MEDICAL MUTUAL BIWEEKLY EMPLOYEE COST			
	Essential Plan		Enhanced Plan	
	Faculty 22 Pay Periods	Non-Faculty 26 Pay Periods	Faculty 22 Pay Periods	Non-Faculty 26 Pay Periods
Single	\$2.99	\$2.53	\$7.90	\$6.69
Employee + 1 Dependent	\$5.68	\$4.80	\$15.03	\$12.72
Family	\$8.36	\$7.08	\$22.14	\$18.73

Rates for all other coverage are not included in this guide, as they vary based on factors such as your coverage level, age, salary and more. Your personalized cost for these coverages will be provided during your enrollment through BenefitPlace on my Tri-C space.



Medical and Prescription Drug Plans

Medical Mutual of Ohio Preferred Choice PPO Plan

A preferred provider organization (PPO) is a medical insurance plan that allows you to see any provider you choose; however, you receive greater benefits when you select in-network providers.

MEDICAL MUTUAL OF OHIO PREFERRED CHOICE PPO PLAN IN-NETWORK DETAILS

In-network deductible	\$500 single/\$1,000 family
Coinsurance limit	\$1,750 single/\$3,500 family
Out-of-pocket maximum	\$4,000 single/\$8,000 family
Preventive care visit copay	\$0
Primary care physician office visit copay	\$20
Specialist office visit copay	\$40
Annual copay limit	\$1,750 single/\$3,500 family
Coinsurance for services	80% for most covered services
Primary care physician (PCP)	Not required
Preventive Vision coverage	One preventive exam every two years with a \$20 copay (age 21 and over)

The Preferred Choice PPO Plan allows you to use out-of-network providers; however, in most cases, it pays 60% of reasonable and customary charges after the deductible.

How do I find an in-network provider?

The Preferred Choice PPO plan utilizes the Medical Mutual SuperMed PPO with the Cigna PPO network. To locate a provider, go to medmutual.com and select "Find a Provider" or call Medical Mutual at 800-315-3137.

Prescription Drug Program for Medical Mutual Preferred Choice PPO Plan

CVS Caremark™ is the prescription provider for the Medical Mutual Preferred Choice PPO plan. You will receive a separate CVS Caremark ID card when enrolling for the first time. The program provides a retail card for purchasing acute, immediate prescriptions and a mandatory mail-order program for long-term prescriptions. After receiving two maintenance medication fills at a retail pharmacy for a 30-day supply, the next refill will need to be at the 90-day supply, which can be mailed to your home or picked up at CVS® or Target® pharmacies.

The table below outlines your copays for prescription drugs under all three tiers, using in-network retail pharmacies or mail-order fulfillment.

	RETAIL (UP TO A 30-DAY SUPPLY)	MAIL ORDER (UP TO A 90-DAY SUPPLY)
Tier	Copay	
Generic	20% (minimum \$5)	\$15
Formulary brand	20% (minimum \$10)	\$45
Non-formulary brand with formulary alternative	20% (minimum \$20)	\$70

Medical Mutual of Ohio

Healthy Saver Plan

The Healthy Saver Plan utilizes the Medical Mutual SuperMed Plus PPO network. This medical plan offers lower biweekly premiums and higher annual deductibles. Your preventive care benefits will continue to be covered at 100% and will not be subject to the deductible. Preventive care includes the following services:

- Annual physical exam and preventive lab tests
- Routine prenatal and well-child care
- Child and adult immunizations
- Preventive screenings (e.g., mammogram, colonoscopy)

One significant advantage of enrolling in the Healthy Saver Plan is the opportunity to contribute to a Health Savings Account.



HEALTHY SAVER PLAN IN-NETWORK DETAILS

In-network deductible	\$3,500 single/\$7,000 family
In-network out-of-pocket maximum (coinsurance and deductible)	\$5,500 single/\$11,000 family
Preventive care visit	\$0
Primary care physician office visit	You pay the Medical Mutual discounted cost until the deductible is met. After the deductible is met, you pay 10%.
Specialist office visit	You pay the Medical Mutual discounted cost until the deductible is met. After the deductible is met, you pay 10%.
Coinsurance for services	90% for most covered services after deductible
Primary care physician (PCP)	Not required

How do I find an in-network provider?

The Healthy Saver Plan utilizes the Medical Mutual SuperMed Plus PPO network. To locate a provider, go to medmutual.com and select “Find a Provider” or call Medical Mutual at 800-315-3137.

Prescription Drug Program for the Medical Mutual Healthy Saver Plan

You pay the CVS Caremark discounted cost until the deductible is met. After the deductible is met, you pay 10%.

IS A HIGH DEDUCTIBLE HEALTH PLAN RIGHT FOR ME?

If the following statements apply to you, then the Healthy Saver Plan may be a good choice:

- I am healthy and only go to the doctor for my annual physical exam.
- I do not take maintenance medications.
- I am a minimal consumer of medical services.

Health Savings Account (HSA)

An HSA allows you to set aside money on a pre-tax basis to pay for qualified out-of-pocket medical expenses. You decide when to take the money out to pay for eligible medical costs. There are many tax advantages with an HSA — your funds grow tax-free, and there are no taxes on withdrawals for eligible medical expenses. Your funds are yours forever, and your balances roll over year to year.

Who Is Eligible To Participate in the HSA?

- Enrolled in the Healthy Saver Plan
- Not covered under another medical plan
- Not enrolled in Medicare
- Not claimed as a dependent on someone's 2022 tax return

2026 HSA CONTRIBUTION LIMITS

	SINGLE	FAMILY*
Maximum Total Allowable Annual Contribution	\$4,400	\$8,750
Annual College Contribution	\$1,500	\$3,000
Employee Maximum Contribution	\$2,900	\$5,750
Employee Age 55 Catch-Up	\$1,000	\$1,000

*Employee plus one or more covered dependents

The College will contribute \$1,500 (single)/\$3,000 (family*) to your HSA. Contributions will be deposited biweekly. Due to IRS regulations, the HSA is not available as a benefit to domestic partners and their children.

Employees can make pre-tax contributions on a biweekly basis up to the annual maximum contribution amounts per the chart above. If you are an eligible individual aged 55 or older by the end of 2025, your contribution limit is increased by \$1,000. Employee contributions will be divided equally among the total number of pays in the year and deducted on a biweekly basis.

You cannot enroll in the Health Care FSA and the HSA simultaneously.

For more information concerning Health Savings Accounts, review IRS Publication 969 at irs.gov/pub/irs-pdf/p969.pdf.

Getting Started With Your HSA

Medical Mutual has partnered with WealthCare Saver to offer the Medical Mutual HSA. Once enrolled, Medical Mutual will automatically open your account and mail out a debit card.

Make Changes to Your HSA Contribution Amount Anytime!

Once enrolled, you can increase, decrease, stop or start your HSA contributions anytime throughout the plan year by submitting your request through Benefitplace.

Delta Dental

With the Delta Dental of Ohio PPO Plan, participants have access to the nation's largest dental networks: Delta Dental PPO™ and Delta Dental Premier®. If you choose an out-of-network dentist, you must pay for all services in full and receive reimbursement from Delta Dental for covered services. Diagnostic and preventive services are covered at 100%. Basic, major and orthodontic services are covered at 50%. Orthodontia is covered for children through age 19.



PLAN SERVICES	SUMMARY OF BENEFITS
Diagnostic and preventive care	100%
Basic and major care	50% after deductible
Annual deductible	\$50 single / \$150 family
Base Annual Benefit Maximum	\$1,000 per person
Increasing Annual Maximum*	\$200 per year to a maximum of \$1,600 per person
Orthodontics	50% dependent children to the end of the month of age 19
Orthodontic Lifetime Maximum	\$1,000 per person

*Increasing Annual Maximum: The maximum payment for the first plan year is \$1,000 per person per year on all services except orthodontic. When you get preventive care in one plan year, you qualify for a \$200 increase in annual benefit maximum coverage the following plan year. Each year thereafter that you receive preventive care, your annual benefit maximum coverage will increase by \$200 until you reach the maximum level of \$1,600.

How Can I Find an In-Network Dentist?

Visit deltadentaloh.com or call Delta Dental Customer Service at 800-524-0149.

Delta Dental Consumer Toolkit

Visit deltadentaloh.com and click on the Consumer Toolkit to verify your benefits, claims and eligibility information. You can also print ID cards, claim forms and more.



Vision Plan Options

The Medical Mutual Vision Plan offers two plan designs to meet your eye care needs:

- The **Essential Plan** covers the basics of healthy vision. The plan includes a comprehensive eye exam and benefits for a basic pair of prescription glasses or contact lenses.
- The **Enhanced Plan** includes all benefits of the Essential Plan and offers higher allowances to cover the cost of your glasses or contact lenses.

Both plans offer services at retail and independent optometrists. Some retail providers include LensCrafters®, Pearle VisionSM and Target Optical. Out-of-network services are available; however, you will receive the best benefit if you stay in the Insight Network of providers.

Member Cost (In-Network)

VISION CARE SERVICES	ESSENTIAL PLAN	ENHANCED PLAN
Exam with dilation	\$0 Copay (every rolling 12 months)	
Frames	Every 24 mos.	Every 12 mos.
	\$0 copay, \$130 allowance	\$0 copay, \$160 allowance
Standard plastic lenses		
Single vision	\$25 copay	\$10 copay
Bifocal	\$25 copay	\$10 copay
Trifocal	\$25 copay	\$10 copay
Standard progressive lens	\$90 copay	\$10 copay
Contact lenses	In lieu of lenses and frames	
Conventional	\$0 copay, \$130 allowance, 20% off balance over \$130	\$0 copay, \$160 allowance, 20% off balance over \$160
Disposable	\$0 copay, \$130 allowance, plus balance over \$130	\$0 copay, \$160 allowance, plus balance over \$160
Additional pairs benefit	40% off complete pair eyeglass purchases and 20% off conventional contact lenses once funded benefit is used	

How do I find an in-network provider?

The Essential and Enhanced vision plans offered by Medical Mutual use the EyeMed Insight network. To locate a provider, go to eyemed.com and select "Find an eye doctor" or call Customer Service at 866-723-0513.

Flexible Spending Accounts

Tri-C offers two types of flexible spending accounts:

- **Health Care FSA** allows you to set aside pre-tax dollars to pay for eligible health care expenses for you, your spouse and other eligible dependents. This account may be used to pay for items such as health care deductibles, copays, prescription drugs, and dental and vision care.
- **Dependent Care FSA** allows you to set aside pre-tax dollars for reimbursement of eligible, employment-related dependent care expenses such as day care for children or elder care for tax-dependent adults.
 - **Federal filing status for dependent care**
Both spouses can each have their own Healthcare FSA through their respective employers and both contribute the maximum amount to each account, However, for the Dependent Care FSA, the annual contribution limit for married couples filing jointly is **\$5,000 combined**.

Your FSA contributions are deducted from your paycheck on a pre-tax basis. The chart below details the minimum and maximum contributions allowed annually for each type.

TYPE OF FSA	MINIMUM CONTRIBUTION	MAXIMUM CONTRIBUTION	ROLLOVER
Health Care FSA	\$180	\$3,400	up to \$550 (available April 1, 2027)
Dependent Care FSA	\$180	\$5,000	\$0

All employees who newly enroll in the FSA for plan year 2026 will receive a Medical Mutual debit card at their home address. Since Medical Mutual is also Tri-C's medical provider, you will have the ability to cross-match expenses paid with the Medical Mutual debit card to charges shown on the Explanation of Benefits (EOB) statement. In order for cross-matching to work, you must swipe your Medical Mutual debit card separately for each transaction. For example, if you are billed \$36 for an urgent care visit and \$27 for an X-ray, you must pay for these transactions separately so they show as individual charges rather than one charge of \$63. This will reduce (but not eliminate) the need for you to substantiate certain expenses charged to your FSA. It is still your responsibility to keep detailed receipts and statements for all services paid by or reimbursed from your FSA.

Due to IRS regulations, the Flexible Spending Accounts are not available as benefits to domestic partners and their children.





Health and Well-Being

The mission of Cuyahoga Community College's Health and Well-Being program is to encourage employees' personal and professional productivity through education and initiatives that:

- Encourage habits centered around well-being
- Increase awareness of factors and resources contributing to well-being
- Inspire and empower individuals to take responsibility for their own health
- Support a sense of community within the College



Well-Being Incentive Program

The Health and Well-Being incentive program helps employees achieve a healthier lifestyle and maintain healthy habits. Participation is optional.

Earn rewards!

Bronze Reward (500 points): \$25
Silver Reward (1,000 points): \$75
Gold Reward (1,500 points): \$175

How to Earn Points

- Track your physical activity, volunteerism and participation in designated Well-Being activities.
- Stay on top of your annual preventive screenings, complete the Preventive Screening Card and submit.
- Complete your online health assessment at medmutual.com.

Well-Being Activities

- Yoga
- Resistance band training
- Step challenges
- And more!

Check your email and the Health and Well-Being KWeb page often for updates.

Impact Solutions and MyLifeExpert

Impact has teamed up with AllOne Health® to provide numerous additional resources.

Log in to mylifeexpert.com (company code: ccceap) to find:

- Getting Fit for Life
Tips and videos to help you live a happier, healthier life
- Eating Well
Easy, wholesome recipes to get you excited about eating right
- Health and Lifestyle Assessments
Quick assessments that provide helpful information focused on your specific needs

Medical Mutual Healthy Living Featuring the Bravo Wellness Portal

Log in to medmutual.com and click "Healthy Living" to access the Wellness Portal.

Disability Benefits

The College offers short-term and long-term disability benefits to help replace a portion of your income if you become ill or injured and are unable to work.

Short-Term Disability Plan

The College pays for short-term disability (STD) benefits that replace 70% of your annual base salary to a maximum of \$3,000 per month (\$4,000 per month AAUP) in the event of a disabling injury or illness. STD is payable after sick and vacation leave have been exhausted or 60 calendar days from the last day worked (whichever is longer).

The maximum benefit period will not exceed 12 months from the last day worked due to disability or six months of receiving benefits (whichever occurs first).

Long-Term Disability Plan

Long-term Disability (LTD) benefits ensure a source of continued income after STD benefits end.

OPERS/STRS Participants

The College pays for LTD benefits that replace 70% of the annual base salary to a maximum of \$3,000 per month. LTD benefits are payable at the end of the STD benefit payment period. LTD benefits are coordinated with OPERS, STRS, Workers' Compensation and Social Security benefits.

ARP Participants

You have the option to participate in the LTD benefit at your own expense on a voluntary basis. Your biweekly LTD benefit premium will be based on the level of coverage elected, your age and annual base pay amount.

Optional Employee-Paid STD or LTD Buy-Up

If you earn more than \$51,429 per year, 70% of your annual base salary will exceed the \$3,000 per month disability benefits threshold.

You may choose to buy additional STD and/or LTD coverage to replace your income if you reach this maximum.

You will still receive a 70% benefit, though only up to a maximum of \$4,000, \$5,000 or \$8,000 (LTD) per month, depending on the benefit you are eligible to receive and the selection you make.

- The buy-up option is only available at the time of hire or during open enrollment.
- Cost is based on your age and salary.

Pre-Existing Condition Limitations for Long-Term Disability Insurance

There is a five-day pre-existing condition limitation for employees who elect LTD coverage for the first time or elect to increase their coverage during an open enrollment period. For new enrollees, conditions that existed within 30 days prior to the insured's effective date will not be covered at an increased level if a disability begins during the first five days of coverage.





Life Insurance Coverage

The College provides life and accidental death and dismemberment (AD&D) insurance at no cost to you.

The standard life and AD&D insurance benefits are each 2.5 times base annual salary, rounded down to the next lowest \$500. The maximum amount of life insurance is \$175,000 (AFSCME \$150,000).

IMPORTANT NOTES ABOUT YOUR LIFE INSURANCE AND AD&D COVERAGE:

- The amount of life insurance is reduced by 50% at age 70.
- Change or update your beneficiary or beneficiaries at any time at lifebenefits.com.
- Life insurance amounts in excess of \$50,000 result in a small amount of taxable income (“imputed income”). The amount varies according to your age and the amount of life insurance over \$50,000.
- If your life insurance ceases because you are no longer an employee or no longer in a class that is eligible for life insurance, you may continue your coverage through an individual policy.
- You may be eligible to request an accelerated benefit if you become terminally ill.

Life Insurance “Buydown” Option

You may “buy down” the amount of life insurance to an amount equal to your annual salary (rounded down to the next lowest \$500) with a maximum of \$50,000 to receive flexible benefits credits that can be applied toward other benefits or received as taxable income.

If you elect to buy down your life insurance benefit, you must provide medical evidence of insurability if you want to return to the standard life insurance benefit during a future annual enrollment. Once you buy down, there is no guarantee that you will be able to return to the standard life insurance benefit.

Additional Benefit Resources

With your life insurance benefit, you and your dependents also have access to the following benefits:

Travel Assistance Services

- For 24/7/365 assistance with emergencies, transport services and pre-trip resources when traveling 50-plus miles from home, call 855-516-5433 U.S./Canada) or 415-484-4677 (other locations).

Legal Services

- For access to a national network of accredited attorneys for consultation on simple wills, estate planning documents and other legal issues, call 877-849-6034 or visit LifeBenefits.com/Lfg (username: lfg; password: resources).

Legacy Planning Services

- For access to online resources for end-of-life issues, visit securian.com/legacy.

Supplemental Life Insurance

You may purchase Supplemental Life Insurance (SLI) valued at one to eight times your annual salary (rounded down to the lowest \$500) to a maximum of \$750,000. This amount includes standard life insurance provided by the College. Coverage reduces to 65% at age 65, 50% at age 70 and 25% at age 75.

As a newly hired employee, SLI will be offered to you with a guaranteed issue amount valued at the lesser of three times your base annual salary (rounded to the lowest \$500) or \$400,000. This means you can purchase up to this amount without providing evidence of insurability.

Dependent Life Insurance

You may choose to purchase dependent life insurance on your eligible dependents. Benefits are paid to you in the event of the death of a covered dependent.



IMPORTANT NOTES ABOUT YOUR DEPENDENT LIFE INSURANCE AND AD&D COVERAGE:

- If your spouse is also an employee and insured under the standard life insurance plan, you cannot insure him or her as a dependent in the dependent life insurance plan.
- If both you and your spouse are covered under the standard life insurance plan, only one of you may enroll for dependent life insurance coverage on your dependent children.
- If you are enrolled in dependent coverage and subsequently acquire a new dependent, that dependent will automatically be covered.
- Dependent life insurance coverage is \$10,000 for all eligible dependent children, regardless of the benefit level of the spouse.
- Your covered dependent may be able to continue coverage through an individual life insurance policy if his or her life insurance ceases.

For the purposes of the dependent life insurance plan, an eligible dependent is:

- Your lawful spouse
- Your domestic partner (and their children) for whom you have completed an Affidavit of Domestic Partnership
- Any unmarried child, from birth to age 26, who lives in your household in a parent-child relationship and is reported by you to the Internal Revenue Service as a dependent

Cost for dependent life insurance, regardless of number of dependents:

BENEFIT LEVEL FOR SPOUSE	BENEFIT LEVEL FOR CHILDREN	BIWEEKLY COST (NON-FACULTY)	BIWEEKLY COST (FACULTY)
\$10,000	\$10,000	\$1.27	\$1.50
\$15,000	\$10,000	\$1.85	\$2.18
\$20,000	\$10,000	\$2.28	\$2.70
\$25,000	\$10,000	\$2.70	\$3.19
\$30,000	\$10,000	\$3.12	\$3.68

When Do You Need To Provide Evidence of Insurability?

You are required to provide Evidence of Insurability (EOI), or proof of good health, if you:

- Purchase additional insurance on your spouse
- Enroll in SLI or dependent life insurance more than 90 days after becoming eligible
- Elect an amount above the guaranteed issue amount

The Total Rewards office will notify you and provide instructions if you are required to provide EOI. Coverage becomes effective on the date the insurance company determines the evidence is satisfactory.





Aetna Supplemental Plans

Medical plans pay health care providers for services and treatment, but they don't cover the unexpected costs that come with an accidental injury, serious illness or hospital stay. The following supplemental plans pay a cash benefit directly to you, allowing you to pay for what you need when you need it. Each plan also offers an annual health screening benefit for enrolled members who receive at least one eligible screening exam.

Accident Insurance

The Aetna Accident Plan pays benefits when you are treated for an accidental injury that occurs off the job. Use the benefits to help pay out-of-pocket medical costs or personal expenses. Accident insurance covers a long list of minor and serious injuries and related expenses in the following categories:

- Initial and follow-up care
- Hospital and surgical care
- Dislocations, fractures and other accidental injuries

Health Screening Benefit

Enrolled participants may file a claim to collect \$100 if they receive any one of 50 eligible health screenings each year.

Note: COVID-19 testing is covered as an eligible health screening benefit.

Organized Sports Rider

If you sustain an accidental injury while playing as a registered member of an organized sporting activity, benefits payable under this certificate may be increased by 25%.

Critical Illness Insurance

The Aetna Critical Illness Plan pays benefits when you or a covered dependent are diagnosed with a serious illness or condition (see list below).

The plan offers three levels of coverage: \$10,000, \$20,000 or \$30,000. Your spouse/domestic partner and/or dependent children receive 100% of the employee benefit amount. Benefits are payable for conditions such as:

- Autoimmune (e.g., Addison's disease, lupus, MS)
- Infectious diseases (e.g., COVID-19, meningitis, bacterial pneumonia)
- Neurological (e.g., ALS, Alzheimer's, coma, Parkinson's, stroke, TIA)
- Other (e.g., end-stage renal or kidney disease; loss of hearing, sight or speech; major organ failure; paralysis; third-degree burns)
- Vascular (heart-related)
- Cancer

Health Screening Rider

Enrolled participants may file a claim to collect \$50 if they receive any one of 50-plus eligible health screenings each year.

Note: COVID-19 testing is covered as an eligible health screening benefit.

Hospital Indemnity Insurance

The Aetna Hospital Indemnity Insurance Plan pays benefits when you have a planned or unplanned hospital stay for an illness or injury, surgery or childbirth. The plan pays a lump-sum benefit for admission and a daily benefit for a covered hospital stay. Use the benefits to pay out-of-pocket medical costs or personal expenses.



BENEFIT AMOUNTS	
Hospital Stay: Admission Day Lump sum for initial day of a hospital stay <i>Max. one stay per plan year</i>	\$1,000
Hospital Stay: Daily (Non-ICU) Daily benefit beginning on Day 2 of non-ICU hospital stay <i>Max. 30 days per plan year</i>	\$100
Hospital Stay: Daily (ICU) Daily benefit beginning on Day 2 of ICU hospital stay <i>Max. 30 days per plan year</i>	\$200
Newborn Routine Care: Daily (Normal pregnancy) Daily benefit for newborn's hospital stay, at least two days (48 hours) following inpatient vaginal delivery or four days (96 hours) following inpatient Cesarean delivery	\$100
Follow-up Care for Maternity: Daily (Normal pregnancy)	\$20

Health Screening Rider

Enrolled participants may file a claim to collect \$50 if they receive any one of 29 eligible health screenings.

Portability

Each supplemental plan is portable, allowing you to keep existing coverage by making direct payments to Aetna in the event of separation from full-time employment at the College.



Employee Assistance Program (EAP)

Life comes with challenges. AllOne Health is here to help you reduce stress, improve mental health, and make life easier by connecting you to the right information, resources and referrals. All services are free, confidential, and available to you and your family members. This includes access to short-term counseling and the wide range of services listed below:

- Mental Health Sessions
- Financial Consultation
- Work-Life Resources
- Life Coaching
- Legal Referrals
- Medical Advocacy

To get started, create your own unique username and password at mylifeexpert.com/login.

Click Sign Up to create a new account.

Enter Tri-C's company code: `ccceap` (all lowercase).

Remission of Fees

You are invited to continue Tri-C's tradition of lifelong learning. As an incentive for taking Tri-C courses, the Remission of Fees program will pay some or all of your instructional fees based on your employee classification. Eligibility for this program, the types of courses covered and reimbursement amounts can vary slightly based on your employee group.

Tuition Reimbursement for Non-Bargaining Employees

The College offers a tuition assistance/reimbursement benefit to all eligible full-time employees for classes taken toward a bachelor's, master's or doctorate. Reimbursable expenses include tuition, lab fees and books.

The maximum calendar year reimbursement is \$5,250.

Reimbursement will only be considered for courses in which you earn a grade of "B" or higher. Employees will be eligible for up to four years of reimbursement per degree and are expected to attend courses during non-working hours.

To be eligible, an employee must have at least two years of continuous, full-time service at the time of the application, along with other qualifications. See [College Procedure 3354: 1-41-02-10](#) for more information.

Your Retirement Benefits

Mandatory Retirement Savings Plans

As a full-time employee of a public higher education institution, you belong to a retirement plan that is part of a public retirement system or an alternative retirement plan (ARP) rather than the Social Security system.



Mandatory Retirement Plan Choices

The State Retirement Plan

1. Ohio Public Employees Retirement System (OPERS) – Non-Faculty
2. State Teachers Retirement System (STRS) – Faculty

The Alternative Retirement Plan (ARP)

1. Full-time employees only – Faculty and Non-Faculty

During the election period, until your election is processed, your retirement funds will be deposited with the applicable State Retirement Plan (OPERS/STRS). If you enroll in the ARP, your employee contributions and eligible employer contributions, beginning on your ARP eligibility date, will automatically transfer to your selected ARP vendor. Your ARP election cancels your service credit and benefits in the State Retirement Plan from your date of hire to your election date.

Your election between the State Retirement Plan and the ARP is irrevocable and cannot be changed while you are continuously employed at the College. It also cannot be changed if you leave employment with the College and are re-employed within 365 days of your separation date.

Election Period

You have 120 days from your date of hire to make a choice between the State Retirement Plan (OPERS/STRS) and the ARP. If you do not make an election, you will default to the applicable State Retirement Plan.

If you elect to stay within the State Retirement Plan, you have plan options to elect from. You have 180 days from your date of hire to make a choice. If you do not make an election, you will default to the Traditional Pension Plan for OPERS or the Defined Benefit Plan for STRS.

Contribution Amounts

Both employee and employer contribution amounts are statutorily determined and codified in the Ohio Revised Code and are subject to change. They cannot be increased nor decreased by the individual employee.

OPERS CONTRIBUTION AMOUNTS

	COLLEGE	EMPLOYEE
Non-Faculty	14%	10%
Law Enforcement	18.1%	13%

STRS CONTRIBUTION AMOUNTS

	COLLEGE	EMPLOYEE
Faculty/Preceptors/Tutors	14%	14%
Faculty/Preceptors/Tutors	14%	14%



ARP CONTRIBUTION AMOUNTS

OPERS-COVERED POSITIONS	COLLEGE	EMPLOYEE
ARP Contributions	11.76%	10%
ARP Contributions Law Enforcement	15.86%	13%
*Mitigating Rate	2.24%	

STRS-COVERED POSITIONS	COLLEGE	EMPLOYEE
ARP Contributions	11.09%	14%
*Mitigating Rate	2.91%	

***Mitigating Rate** – The Ohio Revised Code provides that if the State Retirement Plan determines that the defined contribution plans have had a negative financial impact on the OPERS Traditional Pension or STRS Defined Benefit Plans, then a percentage of the employer contributions shall be redirected to the applicable Traditional Pension or Defined Benefit Plan to compensate for that negative impact. This impact is reviewed each year. Participants accrue no benefits within the OPERS Traditional Pension or STRS Defined Benefit Plans from this contribution.

Overview of the Plans

Ohio Public Employees Retirement System (OPERS) Plan Options

Traditional Pension Plan – This plan is a **defined benefit plan** providing fixed retirement benefits every month of life based on a formula that rewards years of service. The formula includes your years of service credit and final average salary. OPERS manages the investment of employee and College contributions to ensure that funds are available to pay a benefit.

As an employee participating in the Traditional Pension Plan, upon separation of service you may receive your accumulated contributions, interest on those contributions and, if you have five or more years of qualified service credit in the plan, an additional amount that is determined based on your years of service credit.

Member Directed Plan – This plan is a **defined contribution plan** in which employee contributions and a portion of College contributions are deposited into an individual account within the plan for each employee. The employee directs how contributions are invested (within certain limitations) and bears sole responsibility for the investment risk.

With this plan option, you are 100% vested in your employee contributions and any investment earnings (or losses) on those contributions. Depending on the number of years you have attained in the plan, you may also receive a portion of the College's contributions plus any investment earnings (or losses). Your account will vest at a rate of 20% each year for College contributions, with 100% vesting after five years of service.

State Teachers Retirement System (STRS) Plan Options

Defined Benefit Plan – This plan provides a guaranteed retirement benefit based on a formula. The formula uses your age, years of service and final average salary to determine your retirement benefit. STRS manages the investment of employee and College contributions to ensure that funds are available to pay the benefit. Monthly retirement benefits are payable with five or more years of service credit depending upon your age at retirement.

Defined Contribution Plan – In this plan, your retirement income is based on the performance of investment choices you select for the contributions made by you and the College. You may allocate your contributions among various investment options managed by STRS Ohio. This plan is not eligible for combined retirement with other Ohio public pension plans.

You are 100% vested in your employee contributions and any investment earnings (or losses) on those contributions. Depending on the number of years you have attained in the plan, you may also receive a portion of the College's contributions plus any investment earnings (or losses). Your account will vest at a rate of 20% each year for College contributions, with 100% vesting after five years of service.

Combined Plan – This plan combines features of the **defined benefit and defined contribution plans**. College contributions will be contributed to a defined benefit account, and the retirement benefit will be determined based on a formula using your age, years of service and final average salary. Employee contributions will be contributed to the defined contribution account. This portion of the retirement benefit will be determined based on the performance of investment choices you select.

You are fully vested in all of the employee contributions, plus or minus any investment earnings or losses on those contributions. Also, if you have five or more years of qualified service credit, you will be eligible for a retirement benefit from the defined benefit account.

Alternative Retirement Plan (ARP)

This is a 401(a) **defined contribution** plan in which your retirement income is determined based on the performance of investment choices you select for the contributions made by you and the College. You may allocate your contributions among various investment options managed by one of the approved vendors.

Completing the Enrollment Process

Once you have decided which retirement plan you want to participate in, you must take the following action:

1. Complete your Retirement Plan Election Form indicating either the State Retirement Plan or the ARP and submit it to the Total Rewards Office within the 120-day election period. If you choose the ARP, you must open your vendor account before submitting your Retirement Plan Election form to the Total Rewards Office.
2. If you choose the State Retirement Plan, select one of the available plan options and submit that information to OPERS/STRS within the 180-day election period.



FOR MORE INFORMATION ABOUT THE RETIREMENT PLANS

Ohio Public Employees Retirement System (OPERS) | Opers.org | 1-800-222-7377

State Teachers Retirement System (STRS) | Strsoh.org | 1-888-227-7877

ARP Plan Document and List of Approved Vendors is on *my Tri-C Space*



Voluntary Retirement Savings Plans

The College offers 403(b), 457(b) traditional and Roth plan options. Participation in these plans is optional. Funds accumulated in these accounts can be used to supplement retirement benefits from other sources such as OPERS, STRS, ARP or Social Security. Contributions to the 403(b) and traditional 457(b) reduce taxable wages for federal and state purposes but do not reduce wages for determining OPERS, STRS or ARP deductions.

The College does not match contributions to voluntary retirement plans. There are several approved 403(b) and 457(b) vendors for you to choose from. A list of approved vendors is available on the **Total Rewards KWeb page**.

403(b) Tax-Deferred Annuity Plan

A 403(b) plan is a defined contribution retirement plan that allows you to make pre-tax contributions to a 403(b) account in which funds grow tax-deferred until distribution. Distributions at age 59½ or later will be distributed without penalty and taxed at your ordinary tax rate.

Withdrawals prior to age 59½ are subject to IRS regulations. If you make withdrawals before age 59½, these will be taxed as ordinary income and you may be subject to an additional 10% early withdrawal penalty.

457(b) Deferred Compensation Plan

This is a defined contribution retirement plan that allows employees to make pre-tax contributions to an account. These funds grow tax-deferred until you withdraw them at retirement or separation of employment. Distribution options are available at any age upon separation. Upon distribution, funds are taxed at your ordinary tax rate. Roth 457(b) contributions limits are the same as the traditional 457(b) limits.

457(b) Roth Plan Options

In addition to pretax deferrals, our two 457(b) plan vendors — Ohio Deferred Compensation and Voya — also permit Roth 457(b) deferrals, which are made on an after-tax basis. Roth deferrals and associated earnings can be withdrawn tax-free in retirement if qualified distribution requirements are met.

Retirement Manager

Retirement Manager is a convenient, secure, web-based access point from which you can manage your 403(b) plan and Voya Financial 457(b) accounts at any time. The Ohio Deferred Compensation 457(b) and Roth 457(b) plans are excluded from management via Retirement Manager. Users of these plans should continue to access them online or via phone.

Contribution changes must be made online through Retirement Manager.

Visit myretirementmanager.com to get started.

403(b) AND 457(b) ANNUAL CONTRIBUTION LIMITS - 2026

403(b)	457(b) and Roth 457(b)
\$24,500	\$24,500 Combined
Age 50 Catch-Up Provision - \$8,000	Age 50 Catch-Up Provision - \$8,000
Other Annual Catch-Up - \$3,000/yr. · 15 yrs. service with Tri-C · Lifetime Max \$15,000	Other Catch-Up - \$24,500/yr. · Each year for last three yrs. prior to retirement · Cannot be combined with Age 50 Catch-Up
Age 60 to 63 Catch-Up: \$11,250	Age 60 to 63 Catch-Up: \$11,250

This guide offers an overview of your flexible benefits at the College. Full details are available in *my Tri-C space*.

Paid Time Leave

To help you stay healthy, refreshed and ready for work, Tri-C provides a competitive Paid Leave benefit. The number of Paid Leave days you have varies according to your employee group.



Faculty

TYPE OF LEAVE	DETAILS
Sick Leave	<ul style="list-style-type: none"> • 15 days granted at the beginning of the academic year • Earned at a rate of 9.38 hours per month • Maximum accumulation is 180 days (1,350 hours) • Once you reach 10 years of service, you will be paid one quarter of your accumulated sick leave up to a maximum of 45 days at your retirement. This payment will only be made once to each employee. • During the summer, three days of accrued sick leave may be used if necessary. If a death in your immediate family occurs during the summer, these three sick days may be used as bereavement/personal days.
Personal Leave	<ul style="list-style-type: none"> • Six days per year granted at the beginning of the academic year • Earned at a rate of 3.75 hours per month of service

Lecturers

TYPE OF LEAVE	DETAILS
Sick Leave	<ul style="list-style-type: none"> • 15 days granted at the beginning of the academic year • Earned at a rate of 9.38 hours per month
Personal Leave	<ul style="list-style-type: none"> • Six days per year granted at the beginning of the academic year • Earned at a rate of 3.75 hours per month of service

Administrators and Professional Staff

TYPE OF LEAVE	DETAILS
Sick Leave	<ul style="list-style-type: none"> • 15 days granted July 1 • Earned at a rate of 9.38 hours per month • Maximum accumulation is 180 days (1,350 hours) • Once you reach 10 years of service, you will be paid one quarter of your accumulated sick leave up to a maximum of 30 days at your resignation or 45 days at your retirement. This payment will only be made once to each employee.
Vacation Leave	<ul style="list-style-type: none"> • 20 days granted July 1 • Earned at a rate of 12.5 hours per month • Maximum carryover is 45 days (337.5 hours) • Maximum payoff at separation is 30 days (225 hours)
Personal Leave	<ul style="list-style-type: none"> • Four days per year granted July 1 • Earned at a rate of 2.5 hours per month of service
Winter Leave	<ul style="list-style-type: none"> • Three days between the Christmas and New Year's holidays
Consulting Leave	<ul style="list-style-type: none"> • Six days per year granted July 1 • Earned at a rate of 3.75 hours per month of service
Spring Break	<ul style="list-style-type: none"> • Five days for Spring Break as scheduled in the Academic Calendar, typically in mid-March





Non-Bargaining and SEIU Support Staff*

TYPE OF LEAVE	DETAILS
Sick Leave	<ul style="list-style-type: none"> Earned at a rate of 9.38 hours per month Maximum accumulation is 180 days (1,350 hours) Once you reach 10 years of service, you will be paid one quarter of your accumulated sick leave up to a maximum of 30 days at your resignation or 45 days at your retirement. This payment will only be made once to each employee.
Vacation Leave	<ul style="list-style-type: none"> Determined by length of service as of June 30 Maximum carryover as of June 30 is 45 days (337.5 hours) Maximum payoff at separation is 30 days (225 hours).
Personal Leave	<ul style="list-style-type: none"> Four days per year granted July 1 Earned at a rate of 2.5 hours per month of service
Winter Leave	<ul style="list-style-type: none"> Three days between the Christmas and New Year's holidays
Spring Break	<ul style="list-style-type: none"> Five days for Spring Break as scheduled in the Academic Calendar, typically in mid-March

*Accruals for employees classified as dispatchers and building grounds supervisors are based on eight hours per day.

Vacation Leave Accrual Schedule

LENGTH OF SERVICE	BARGAINING/NON-BARGAINING SUPPORT STAFF			
	Exempt		Non-exempt	
	Monthly Accrual	Annual	Monthly Accrual	Annual
1 month - 5 years	1.25 days	15 days	0.83 day	10 days
6 years	1.42 days	17 days	1 day	12 days
7 years	1.5 days	18 days	1.08 days	13 days
8 - 14 years	1.67 days	20 days	1.25 days	15 days
15 years +	1.67 days	20 days	1.67 days	20 days

You must be an active employee on the 15th of the month to accrue leave for that month.

Leave balances will update with accruals on the last pay of the month.

For employees whose employment with the College ended for a time period in the past, but who have since returned to employment with Tri-C, "length of service" includes prior service only if the break in employment was less than one calendar year.

AFSCME

TYPE OF LEAVE	DETAILS
Sick Leave	<ul style="list-style-type: none"> Earned at a rate of 10 hours per month Maximum accumulation is 180 days (1,440 hours) Once you reach 10 years of service, you will be paid one quarter of your accumulated sick leave up to a maximum of 45 days at your retirement. This payment will only be made once to each employee.
Vacation Leave	<ul style="list-style-type: none"> Determined by length of service as of May 31 May carry over accrued but unused time to the next fiscal year, but amount of carryover shall not exceed the amount accrued during the two previous fiscal years. At separation, you will be paid for any accrued but unused time accumulated as the date of separation. The maximum payoff at separation is 30 days (240 hours). See the Vacation Leave Accrual Schedule below for additional details.
Personal Leave	<ul style="list-style-type: none"> Four days per year granted July 1 Earned at a rate of 2.67 hours per month of service
Winter Leave	<ul style="list-style-type: none"> Three days between the Christmas and New Year's holidays
Spring Break	<ul style="list-style-type: none"> Five days for Spring Break as scheduled in the Academic Calendar, typically in mid-March



If you leave employment with Tri-C prior to the end of the fiscal year, any leave taken in excess of leave earned will be deducted from your final paycheck.

Vacation Leave Accrual Schedule (AFSCME)

LENGTH OF SERVICE	ANNUAL (WEEKS)
1 month - 5 years	2
6 years	2, plus 2 days
7 years	2, plus 3 days
8 - 14 years	3
15 years or more	4

Your vacation days are granted upon date of hire and determined by length of service as of May 31.

For employees whose employment with the College ended for a time period in the past, but who have since returned to employment with Tri-C, "length of service" includes prior service only if the break in employment was less than one calendar year.

Provider Contact Information



Medical Mutual (Medical Plans)

Plan Group Number: 920190
 Customer Care: 800-315-3137
 Nurse Line: 888-912-0636
 medmutual.com



CVS Caremark (Prescription Plan)

(Retail & Mail Order)
 Plan Group Code: RX1764
 800-776-1355
 caremark.com



Delta Dental (PPO Dental Plan)

Group #: 2515
 800-524-0149
 deltadentaloh.com



EyeMed (Vision Plan)

EyeMed (Vision Plan)
 EyeMed INSIGHT Network
 866-723-0513
 eyemed.com



Aetna Supplemental Plans

(Accident, Critical Illness, Hospital Indemnity Insurance)
 800-607-3366
 myaetnasupplemental.com



Securian Financial

(Life Insurance Beneficiary Updates)
 lifebenefits.com
 Password Reset: 800-815-7636



Flexible Spending Accounts

Administered by Medical Mutual
 800-525-9252
 medmutual.com



Health Savings Account

Administered by Medical Mutual
 800-522-2037
 medmutual.com



AllOne Health

Employee Assistance Program
 800-227-6007 (24/7)
 mylifeexpert.com/login
 Company Code: ccceap
 Login Assistance: 404-767-0064



AIG: 216-643 6340
 Equitable Advisors: 216-621-7715
 TIAA: 800-842-2273
 Voya: 216-447-3789



Ohio Public Employees Retirement System (OPERS)

800-222-7377
 614-466-2085
 opers.org



State Teachers Retirement System (STRS) Ohio

888-227-7877
 614-227-4090
 strsoh.org

Your Benefits Team

Erica Sabo

Manager, Benefits
 erica.sabo@tri-c.edu
 216-987-0485

For questions about:

- Health and Welfare Benefit Plans
- FSA or HSA
- Supplemental Benefits
- Paid Time Off
- Retirement Plans

Amy Campoy

Benefits and Well-Being Administrator
 amy.campoy@tri-c.edu
 216-987-3498

For questions about:

- Well-Being Program
- Health and Welfare Benefit Plans
- Adding/Removing Dependents

Riya Surti

Leave Administrator
 riya.surti@tri-c.edu
 216-987-4736

For questions about:

- FMLA/Leave of Absence
- ADA
- Workers' Compensation

Tanja Foster

Director, Benefits
 tanja.foster@tri-c.edu
 216-987-4845

- Directs Collegewide Benefits Plans, Retirement Plans, Leave Administration, ADA, W/C and Well-Being Program

LEGAL NOTICES AND YOUR RIGHTS

If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, a Federal law gives you more choices about your prescription drug coverage. Please see page 27 for more details.

MAKING CHANGES TO YOUR COVERAGE DURING THE YEAR

In general, the benefit plans and coverage levels you choose when you are first enrolled remain in effect for the remainder of the plan year in which you are enrolled. Elections you make at Open Enrollment generally remain in effect for the following plan year (Jan. 1 through Dec. 31).

If you experience one of the events described below and want to make a change to your coverage due to that event, you must notify the College within 30 days of the event, or 60 days for certain events as described under the HIPAA Special Enrollment Events section. If you do not notify the College within the 30-day period, you will not be able to make any changes to your coverage until the next Open Enrollment period.

CHANGES IN STATUS

You may be able to change your Medical, Dental, Vision, Life/AD&D and Health Care Flexible Spending Account or Dependent Care Flexible Spending Account elections during the plan year if you experience a change in status. Please note that in order to change your benefit elections due to a change in status, you may be required to show proof verifying that these events have occurred (e.g., copy of marriage certificate, birth certificate, divorce decree). These rules apply to elections you make for your Medical, Dental, Vision, Life/AD&D coverages and Health Care and Dependent Care Flexible Spending Account. The following is a list of changes in status that may allow you to make a change to your elections (as long as you meet the consistency requirements, described below).

- Legal marital status: Any event that changes your legal marital status, including marriage, divorce, death of a spouse, legal separation or annulment
- Number of eligible dependents: Any event that changes your number of eligible dependents including birth, death, adoption, legal guardianship or placement for adoption
- Employment status: Any event that changes your or your eligible dependents' employment status that results in gaining or losing eligibility for coverage. Examples include:
 - Beginning or ending employment;
 - A strike or lockout;
 - Starting or returning from an unpaid leave of absence;
 - Changing from part-time to full-time employment or vice versa; or
 - A change in work locations.

- Dependent status: Any event that causes your dependents to become eligible or ineligible for coverage because of age, student status or similar circumstances
- Residence: A change in the place of residence for you or your eligible dependents if the change results in your or your eligible dependents living outside your medical or dental plan's network service area
- HIPAA Special Enrollment Events: Events such as the loss of other coverage that qualify as special enrollment events under Health Insurance Portability and Accountability Act (HIPAA)
- FMLA leave: Beginning or returning from an FMLA leave

Permitted changes in status will include change in status events affecting nondependent children under age 26, including becoming newly eligible for coverage or eligible for coverage beyond the date on which the child otherwise would have lost coverage.

CONSISTENCY REQUIREMENTS FOR CHANGES IN STATUS

Except for election changes due to a HIPAA special enrollment, the changes you make to your coverage must be "on account of and correspond with" the event. To satisfy the "consistency rule," both the event and the corresponding change in coverage must meet all of the following requirements.

- Effect on eligibility: The event must affect eligibility for coverage under the Plan or under a plan sponsored by your dependent's employer. This includes any time you become eligible (or ineligible) for coverage or if the event results in an increase or decrease in the number of your dependent child(ren) who may benefit from coverage under the Plan.
- Corresponding election change: The election change must correspond with the event. For example, if your dependent child(ren) loses eligibility for coverage under the terms of the health plan, you may cancel health coverage only for that dependent child(ren). You may not cancel coverage for yourself or other covered dependents.

HIPAA SPECIAL ENROLLMENT EVENTS

If you decline enrollment for medical benefits for yourself or your eligible dependents because of other health insurance or group health plan coverage, you may be able to enroll yourself and your eligible dependents (including domestic partners) in the medical benefits provided under this Plan if you or your eligible dependents lose eligibility for

that other coverage (or if the other employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 30 days after your or your eligible dependents' other coverage ends (or after the other employer stops contributing toward the other coverage).

In addition, if you have a new dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself, your spouse and your new eligible dependent children. However, you must request enrollment within 30 days after the marriage, birth, adoption or placement for adoption. The Plan is not required to extend all of the HIPAA special rules for a newly acquired domestic partner; however, you may still be able to add them to the Plan as described in the Change in Status section.

If you request a change due to a special enrollment event within the 30-day timeframe, coverage will be effective the date of birth, adoption or placement for adoption. For all other events, coverage will be effective the first of the month following your request for enrollment.

The Plan will also allow HIPAA special enrollment for employees and dependents (including domestic partners) who are eligible but not enrolled if they lose Medicaid or CHIP coverage because they are no longer eligible, or they become eligible for a state's premium assistance program. Employees have 60 days from the date of the Medicaid/CHIP event to request enrollment under the Plan. If you request this change, coverage will be effective the first of the month following your request for enrollment. Specific restrictions may apply, depending on federal and state law.

To request special enrollment or obtain more information, contact Cuyahoga Community College, 2500 E. 22nd St., Cleveland, Ohio 44115.

OTHER EVENTS THAT ALLOW YOU TO CHANGE ELECTIONS

Entitlement to Government Benefits

- If you or your eligible dependents become entitled to or lose entitlement to Medicare or Medicaid, or lose entitlement to certain other governmental group medical programs, you may make a corresponding change to your Medical and Dental coverages and Health Care Flexible Spending Account elections.

QMCSOS

If a Qualified Medical Child Support Order (QMCSO) requires the Plan to provide

coverage to your child, then the Plan Administrator may automatically change your election under the Plan to provide coverage for that child. In addition, you may make corresponding election changes as a result of the QMCSO.

If the QMCSO requires another person (such as your spouse or former spouse) to provide coverage for the child, then you may cancel coverage for that child under the Plan if you provide proof to the Plan Administrator that such other person actually provides the coverage for that child.

SPECIAL RIGHTS FOR MOTHERS AND NEWBORN CHILDREN

For the mother or newborn child, the Plan will not restrict benefits for any hospital length of stay in connection with childbirth to less than 48 hours following a vaginal delivery or 96 hours following a Cesarean section. However, the mother's or newborn's attending provider, after consulting with the mother, may discharge the mother or her newborn earlier than 48 hours (or 96 hours, as applicable). In any case, no authorization is required from the Plan or an insurance company for a length of stay that does not exceed 48 hours (or 96 hours).

WOMEN'S HEALTH AND CANCER RIGHTS ACT

The Plan will provide certain coverage for benefits received in connection with a mastectomy, including reconstructive surgery following a mastectomy. This benefit applies to any covered employee or dependent, including you, your spouse and your dependent child(ren).

If the covered person receives benefits under the Plan in connection with a mastectomy and elects breast reconstruction, the coverage will be provided in a manner determined in consultation with the attending physician and the covered person. Coverage may apply to:

- 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 at all stages of the mastectomy, including lymphedemas.

Benefits for breast reconstruction are subject to annual Plan deductibles and coinsurance provisions that apply to other medical and surgical benefits covered under the Plan.

Cuyahoga Community College Privacy Notice

YOUR INFORMATION. YOUR RIGHTS. OUR RESPONSIBILITIES.

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

Your Rights

You have the right to:

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

Your Choices

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

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

Our Uses and Disclosures

We may use and share your information as we:

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

Your Rights

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

Get a copy of health and claims records

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

Ask us to correct health and claims records

- You can ask us to correct your health and claims records if you think they are incorrect or incomplete. Ask us how to do this.
- We may deny your request, but will explain why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.

- We will consider all reasonable requests, and must comply if you tell us you would be in danger if we do not.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment or our operations.
- We are not required to agree to your request, and we may deny the request if it would affect your care.

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

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

Get a copy of this privacy notice

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

Choose someone to act for you

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

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends or others involved in payment for your care
- Share information in a disaster relief situation

If you are not able to tell us your preference

(for example, if you are unconscious) we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we never share your information unless you give us written permission:

- Marketing purposes
- Sale of your information

Our Uses and Disclosures

How do we typically use or share your health information?

We typically use or share your health information in the following ways:

Help manage the health care treatment you receive

We can use your health information and share it with professionals who are treating you.

Example: A doctor sends us information about your diagnosis and treatment plan so we can arrange additional services.

Run our organization

- We can use and disclose your information to run our organization and contact you when necessary.
- We are not allowed to use genetic information to decide whether we will give you coverage and the price of that coverage. This does not apply to long-term care plans.

Example: We use health information about you to develop better services for you.

Pay for your health services

We can use and disclose your health information as we pay for your health services.

Example: We share information about you with your dental plan to coordinate payment for your dental work.

Administer your plan

We may disclose your health information to your health plan sponsor for plan administration.

Example: Your company contracts with us to provide a health plan, and we provide your company with certain statistics to explain the premiums we charge.

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

Help with public health and safety issues

We can share health information about you for certain situations such as:

- Preventing disease

- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research

We can use or share your information for health research.

Comply with the law

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests and work with a medical examiner or funeral director

- We can share health information about you with organ procurement organizations.
- We can share health information with a coroner, medical examiner or funeral director when an individual dies.

Address workers' compensation, law enforcement and other government requests

We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security and presidential protective services

Respond to lawsuits and legal actions

We can share health information about you in response to a court or administrative order or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

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

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request on our website, and

we will mail a copy to you.

Effective Aug. 26, 2016

Privacy Officer: Arcola Whatley,
arcola.whatley@tri-c.edu, 216-987-4883

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

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

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

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
2. Cuyahoga Community College has determined that the prescription drug coverage offered by the Electives Flexible Benefits Plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

WHEN CAN YOU JOIN A MEDICARE DRUG PLAN?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from Oct. 15 to Dec. 7.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two-month Special Enrollment Period (SEP) to join a Medicare drug plan.

WHAT HAPPENS TO YOUR CURRENT COVERAGE IF YOU DECIDE TO JOIN A MEDICARE DRUG PLAN?

If you decide to join a Medicare drug plan, your current Cuyahoga Community College coverage will not be affected.

Individuals can keep their coverage under the CVS Caremark plan if they elect Part D, and this plan will coordinate with Part D coverage.

If you do decide to join a Medicare drug plan and drop your current Cuyahoga Community College coverage, be aware that you and your dependents will be able to get this coverage back.

WHEN WILL YOU PAY A HIGHER PREMIUM (PENALTY) TO JOIN A MEDICARE DRUG PLAN?

You should also know that if you drop or lose your current coverage with Cuyahoga Community College and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

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

FOR MORE INFORMATION ABOUT THIS NOTICE OR YOUR CURRENT PRESCRIPTION DRUG COVERAGE

Contact the Office of Human Resources' Total Rewards department at 216-987-0485.

NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through Cuyahoga Community College changes. You may also request a copy of this notice at any time.

FOR MORE INFORMATION ABOUT YOUR OPTIONS UNDER MEDICARE PRESCRIPTION DRUG COVERAGE

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

For more information about Medicare prescription drug coverage:

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

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

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

EMPLOYEE RIGHTS AND RESPONSIBILITIES UNDER THE FAMILY AND MEDICAL LEAVE ACT

LEAVE ENTITLEMENTS

Eligible employees who work for a covered employer can take up to 12 weeks of unpaid, job-protected leave in a 12-month period for the following reasons:

- The birth of a child or placement of a child for adoption or foster care
- To bond with a child (Leave must be taken within one year of the child's birth or placement)
- To care for the employee's spouse, child or parent who has a qualifying serious health condition
- For the employee's own qualifying serious health condition that makes the employee unable to perform the employee's job
- For qualifying exigencies related to the foreign deployment of a military member who is the employee's spouse, child or parent

An eligible employee who is a covered servicemember's spouse, child, parent or next of kin may also take up to 26 weeks of FMLA leave in a single 12-month period to care for the servicemember with a serious injury or illness.

An employee does not need to use leave in one block. When it is medically necessary or otherwise permitted, employees may take leave intermittently or on a reduced schedule.

Employees may choose, or an employer may require, use of accrued paid leave while taking FMLA leave. If an employee substitutes accrued paid leave for FMLA leave, the employee must comply with the employer's normal paid leave policies.

BENEFITS AND PROTECTIONS

- While employees are on FMLA leave, employers must continue health insurance coverage as if the employees were not on leave.
- Upon return from FMLA leave, most employees must be restored to the same job or one nearly identical to it with equivalent pay, benefits and other employment terms and conditions.
- An employer may not interfere with an individual's FMLA rights or retaliate against someone for using or trying to use FMLA leave, opposing any practice made unlawful by the FMLA or being involved in any proceeding under or related to the FMLA.

ELIGIBILITY REQUIREMENTS

An employee who works for a covered employer must meet three criteria in order to be eligible for FMLA leave:

- Have worked for the employer for at least 12 months;
- Have at least 1,250 hours of service in the 12 months before taking leave*; and
- Work at a location where the employer has at least 50 employees within 75 miles of the employee's worksite.

*Special "hours of service" requirements apply to airline flight crew employees.

REQUESTING LEAVE

Generally, employees must give 30-days advance notice of the need for FMLA leave. If it is not possible to give 30-days notice, an employee must notify the employer as soon as possible and, generally, follow the employer's usual procedures.

Employees do not have to share a medical diagnosis, but must provide enough information to the employer so it can determine if the leave qualifies for FMLA protection. Sufficient information could include informing an employer that the employee is or will be unable to perform his or her job functions; that a family member cannot perform daily activities; or that hospitalization or continuing medical treatment is necessary. Employees must inform the employer if the need for leave is for a reason for which FMLA leave was previously taken or certified.

Employers can require a certification or periodic recertification supporting the need for leave. If the employer determines that the certification is incomplete, it must provide a written notice indicating what additional information is required.

EMPLOYER RESPONSIBILITIES

Once an employer becomes aware that an employee's need for leave is for a reason that may qualify under the FMLA, the employer must notify the employee if he or she is eligible for FMLA leave and, if eligible, must also provide a notice of rights and responsibilities under the FMLA. If the employee is not eligible, the employer must provide a reason for ineligibility.

An employer must notify its employees if leave will be designated as FMLA leave and, if so, how much leave will be designated as FMLA leave.

ENFORCEMENT

Employees may file a complaint with the U.S. Department of Labor, Wage and Hour Division or may bring a private lawsuit against an employer. The FMLA does not affect any federal or state law prohibiting discrimination or supersede any state or local law or collective bargaining agreement that provides greater family or medical leave rights.





Ask the Experts

Contact the Total Rewards team with questions about your Tri-C flexible benefits program.

Erica Sabo: Ext. 0485
Amy Campoy: Ext. 3498
Riya Surti: Ext. 4736
Tanja Foster: Ext. 4845

This document provides a summary of the Cuyahoga Community College Electives Flexible Benefits Program effective Jan. 1, 2026. Eligibility and plan provisions are governed by the respective plan documents. If there is a discrepancy between this information and the official plan document, the official documents will always govern.

