

**CLEVELAND
METROPOLITAN SCHOOL
DISTRICT**

**2010
OPEN
ENROLLMENT
BENEFITS
SUMMARY**

IMPORTANT INFORMATION

OPEN ENROLLMENT PERIOD IS NOVEMBER 1, 2009 - NOVEMBER 30, 2009.

All changes must be made by Midnight on November 30, 2009.

The November 2009 Open Enrollment is for employees enrolled in Cleveland Metropolitan School District Employee Benefit Plans. If you are currently enrolled in the Medical/w/drug, Dental, Vision or Life Insurance plans, and are satisfied with your current benefit coverage, you do NOT need to take any action. Your 2009 elections will roll over into 2010 with no change. Life insurance rates will be adjusted for age bands automatically.

If you want to make changes to your plan selections, **ADD A SPOUSE BACK** to primary coverage, add or delete a dependent, make a change to your voluntary or portable life insurance, or **participate in the Flexible Spending Account Plan (FSA)**, you **must** re-enroll. If you Opted-Out of medical coverage last year, you must Opt-Out of coverage again for 2010 and show proof of other coverage. The 2009 medical coverage Opt-Out will not be carried over.

YOU MUST USE THE INTERNET TO ENROLL OR MAKE C HANGES IN YOUR BENEFITS.

Beginning November 1, 2009, you can click on the Open Enrollment 2010 link on the District's home page (www.cmsdnet.net). Once you click on this link, it will take you to the benefits instruction page. On this page, you can access the 2010 Open Enrollment Summary, which provides detailed information about the health/w/drug, dental, vision, Flexible Spending Accounts and life insurance options that are available to you.

You must elect your benefits via the INTERNET ONLY. Go to www.cmsdjobs.com/esjobs/benefits.asp or click the Open Enrollment 2010 link on the District's home page from November 1, 2009 through midnight on November 30, 2009. A paper enrollment is not available. Your PIN is the same as last year, unless you made a change. If you want to view your current coverage, go to www.cmsdjobs.com/esjobs/benefits.asp and follow the Enrollment Instructions and Helpful Hints.

If you are currently enrolled in a Dental/Vision or Dependent Care Spending Account, you **must** make a new election. The amount you selected for 2009 will not be carried over. If you have not participated in the past, you may now enroll in this tax savings plan.

As part of 2007 negotiations between the Cleveland Metropolitan School District and its bargaining unions, legal spouses may be ADDED BACK to primary coverage. Please refer to details later in this summary for additional information.

CLEVELAND METROPOLITAN SCHOOL DISTRICT DEPENDENT ELIGIBILITY.

As part of our continuing effort to control rising healthcare costs, Cleveland Metropolitan School District will require Dependent Eligibility confirmation documents when adding dependents to the plan coverage. The purpose of these records is (1) to update the records of all covered family members, (2) to confirm that each dependent is eligible for benefits under the rules of the medical plan, and (3) to remove any ineligible dependents. Your cooperation is appreciated in providing the necessary documents when adding dependents to the CMSD employee benefit plans.

HOW TO ENROLL OR MAKE A CHANGE

IMPORTANT: If you are currently enrolled in Aetna, Kaiser or Medical Mutual plans, and are satisfied with your current benefit coverage, you do not need to take any action!

STEP 1: Read this **Enrollment Benefits Summary**. It is designed to summarize all the important points about the group insurance program.

STEP 2: Use the Internet to view/enroll/change/add/delete/opt-out. You can enroll at home, at work, or at any library. The system is available 24 hours per day, 7 days per week (November 1, 2009 – November 30, 2009). Detailed enrollment instructions are located on the **Enrollment Instructions and Helpful Hints** page. Following these instructions will make your enrollment as simple as 1-2-3!

STEP 3: After you have enrolled via the Internet, a **Confirmation Statement** will be mailed to your home. Please review all the information on this statement. If the information is correct, sign the statement, keep a copy for your records and return the original signed statement to Human Resources – Employee Benefits Department-500N by the deadline noted on your statement.

NOTE: If you add a spouse back to coverage or any dependents under your coverage, *you must* return the Confirmation Statement with one of the following official documents: 1) Marriage license with date of marriage, 2) Birth certificate, or 3) Adoption/Guardianship document.

NOTE: You must designate your life insurance beneficiaries in writing with your signature. Therefore, the Confirmation Statement must be returned with your signature to Human Resources – Employee Benefits Department-500N. Should you experience a life insurance claim and a beneficiary is not designated, the insurance company will, within the law, determine to whom the life insurance proceeds are granted. To avoid any misunderstanding, please sign the Confirmation Statement, keep a copy for your records and return the original copy to Human Resources – Employee Benefits Department-500N promptly.

OPT-OUT RULES

Follow these instructions to decline medical coverage:

STEP 1: You **MUST use the online system** to enroll and select “Opt-Out” in the medical coverage option.

STEP 2: You **MUST** submit proof of other medical coverage (coverage not provided by the Cleveland Metropolitan School District) by January 31, 2010 with your signed Confirmation Statement.

STEP 3: Opt-Out payments will be included in the second paychecks in April and October 2010. **No payments will be issued without proof of other medical coverage.**

STEP 4: If you wish to waive coverage for your eligible family members and elect single coverage for yourself, you must list your eligible dependents in the dependents section.

NOTE: If two married employees both work for the District, neither employee can opt-out of coverage and receive the cash payment. Opt-Out guidelines may vary per union agreement. Refer to your labor agreement for specific Opt-Out guidelines.

ENROLLMENT INSTRUCTIONS & HELPFUL HINTS

To Access the Benefits Enrollment System:

1. Go to www.cmsdjobs.com/esjobs/benefits.asp or simply click on the Open Enrollment 2010 link on the District's Home page (www.cmsdnet.net).
2. Click on "View Benefit Enrollment".
3. Enter your 9 digit Social Security Number (do not use hyphens).
4. Enter your 4 digit PIN (Personal Identification Number). Your PIN is printed in the box at the top right-hand corner of your Open Enrollment letter.
5. When you enter the enrollment system, you will view your current personal information, health insurance, life insurance and beneficiaries on the Home page.
6. If no changes are needed, just click on the Log Out tab.

To Enroll, Make a Change or Opt-Out of Coverage:

1. Click on the "Edit Selections" tab at the top of the page or click on the "Edit Information" button at the bottom of the Home page.
2. Select "Open Enrollment" from the "Life Event" drop-down box. The effective date 1/1/2010 is shown. Click on the "Next" button.
3. The next page shows your personal information. You may update your address and telephone number here.
4. On the Medical Insurance page, select your medical/drug, dental and vision plan and the coverage level for each. **If you do not wish to enroll in a CMSD Insurance Plan, please select the "Opt-Out" option.**
5. Click on the "Add Dependent" button in the Dependents section to enter the name of your **legal spouse** and/or dependent child(ren) to be covered. Click on the "Next" button.
6. On the Life Insurance page, enter your beneficiary designation for the Basic Life Insurance. You may also elect additional life insurance and name beneficiaries for these additional plans. Click on the "Next" button. The Summary page will appear.
7. Carefully review the Summary page to ensure that all information is correct. If you need to make additional changes, click on the "Previous" button at the bottom of the page.
8. When you are satisfied with your elections, click on the "Submit" button. Your confirmation page with a confirmation number will appear.
9. Your benefit elections will not be registered until you receive a confirmation number. If you need to make a change after you have enrolled, you may do so by following Steps 1 – 8 again.
10. The last confirmation number you receive is the final record used for benefits enrollment. **Please print your confirmation page for your records before you log out.** An updated confirmation statement will be mailed to you.
11. If your Internet connection is terminated during the enrollment process, all elections will be lost and you will need to begin again.
12. If you press the Delete Information button (at the bottom of the confirmation number page), all elections will be lost and you will need to begin again.

If you Opted-Out of medical coverage last year, you must Opt-Out of coverage again for the 2010 plan year and show proof of other coverage. The 2009 medical coverage Opt-Out will not be carried over.

Helpful Hints and Information:

1. Each time you access the website, you will be able to view your current enrollment information by clicking on the Home tab.
2. You can change your PIN by clicking on the Options tab. You can use any four-digit number for your PIN.
3. If you experience a change in status (marriage, divorce, newborn, adoption, etc.) subsequent to the open enrollment period, you can update your coverage, provided you notify the Human Resources – Employee Benefits Department in writing within 30 days following the change. You can call 216-574-8252 for information.
4. To navigate through the enrollment system:
 - a. **Do not use browser buttons to navigate through the benefits enrollment system (e.g., Refresh, Forward and Back buttons).**
 - b. The “Next” button will move you forward to the next page.
 - c. The “Previous” button will move you back to the previous page. Any changes you have made on other pages will be stored.
 - d. The “Go Back” button will move you back to the previous page, **but any changes you already made will be lost.** The system will prompt you for confirmation before this action is completed.
 - e. The “Cancel” button will erase any changes that were made and bring you back to the Home page. The system will prompt you for confirmation before this action is completed.
5. You can click on the plan name to find more information (i.e., click on “Kaiser HMO” on the medical insurance page to see more information about the coverage).
6. The enrollment system will not allow you to move forward if certain information is not entered (e.g., Primary Care Physician information for anyone enrolled in the Kaiser HMO plan).
7. If your Internet connection is terminated during the enrollment process, all elections will be lost and you will need to begin again.
8. If you press the Delete Information button (at the bottom of the confirmation number page), all elections will be lost and you will need to begin again.
9. In addition to this summary plan, there may be other plan provisions and limitations that apply. The Certificate of Coverage or plan document for each provider will prevail. See a Certificate of Coverage for details or contact each provider for additional information. The providers contact information is located in this summary.

EMPLOYEE ELIGIBILITY RULES (MEDICAL, DENTAL AND VISION)

Covered Employees	Generally all employees who are not substitutes and who work at least 19 hours per week on a routine basis are eligible for benefits the first of the month following one (1) full month of employment. Building substitutes are considered “covered employees”.
Substitute Employees	Substitute teachers are eligible as defined in the CTU/District Collective Bargaining Agreement.
Part-Time Employees	Employees who work less than 19 hours per week are not eligible for benefits.

DEPENDENT ELIGIBILITY RULES (MEDICAL, DENTAL AND VISION)

Legal Spouse	Covered. (See Employee Benefits – Spouse Eligibility on this summary for details).
Eligible Dependent Children	Unmarried children, including stepchildren, newborn and legally adopted children living with you at least 50% of the time and the child is claimed as a federal tax dependent.
Age Limit	Coverage is extended to eligible dependents, until the end of the month in which the child attains age 19, <u>unless allowed as a federal tax exemption</u> , then to the end of the month in which the child attains age 23. It is required that college students attend degree-granting institution; that they must be enrolled for a minimum of 12 hours per term for undergraduate and a minimum of 6 hours per term for graduate; that vocational schools be accredited by a national governing body and licensed by the State. It also requires that any valid vocational school training program be a minimum of 500 hours to graduate.
Legal Guardian Children	Unmarried children for whom the participant or the participant’s spouse is a legal guardian. The participant must submit an application within 30 days of the date legal guardianship is approved by the court.
Disabled Children	Eligibility will continue past the age limit only for those unmarried dependents who cannot work to support themselves due to an eligible disability. These dependents must be allowed as a federal tax exemption.
PROOF OF DEPENDENT ELIGIBILITY	The District will verify dependent eligibility by requiring submission of official documents, such as: 1) Marriage license with date of marriage, 2) Birth certificate, or 3) Adoption/Guardianship document.

Note: It is possible that a person living in your home may not qualify for coverage. Please read these rules carefully to know who is eligible for coverage. All covered services are subject to the conditions, exclusions, limitations, terms and provisions of the Certificate of Insurance issued by the carrier; including any attachments and riders. Please contact Human Resources – Employee Benefits Department at (216) 574-8252 if you need help to find out if a particular person living in your home is eligible for coverage.

A misrepresentation can lead to discipline, up to and including discharge, as well as reimbursement to third parties for any claims paid as a result of the misrepresentation.

SECTION 125 PLAN

The Section 125 Plan is a plan governed by Internal Revenue Service (IRS) Regulations, which allows an employee to pay insurance premiums on a pre-tax basis (e.g. the monthly premiums in the collective bargaining agreements), as well as Vision/Dental or Dependent Care Flexible Spending Account eligible expenses. Thus, this program allows the District to deduct your premiums for certain group insurance plans from your paycheck before taxes are calculated, thereby lowering your taxable income and potentially reducing your taxes.

Your pre-tax elections must be made on an annual basis. The rules do not allow you to make a change in your annual elections during the plan year unless the change you make is because of and consistent with “an IRS qualified change in status”; and you notify Human Resources – Employee Benefits Department of your “change in status” in writing within 30 days following the change.

The definition of a “change in status” includes marriage, birth/adoption, divorce, a dependent who becomes ineligible for coverage (e.g. because of age) or certain change of work status experienced by you or your spouse.

Medical Benefit Summary

Benefits	KAISER HMO Network Only (No coverage if outside Kaiser, except in emergency)	AETNA Network / Non-Network	MMO-SUPERMED SELECT POS Authorized/ Non-Authorized	MMO-SUPERMED PLUS PPO Network / Non-Network
Hospital Services (Emergency Co-pay (ER), Urgent Care Co-pay (UC))	\$20 Co-pay (ER) \$ 0 Co-pay (UC)	\$75 Co-pay (ER) \$35 Co-pay (UC) / 70%	\$75 Co-pay (ER) \$35 Co-pay (UC) / 70%	\$75 Co-pay (ER) \$35 Co-pay (UC) / 80%
Physician Services (Office Visit)	\$10 Co-pay	\$15 Co-pay / 70%	\$15 Co-pay / 70%	\$15 Co-pay / 80%
Physician Services (Surgery, 2 nd Surgery Opinion)	100%	100% / 70%	100% / 70%	100% / 80%
Physician Services (X-Ray & Lab)	100%	100% / 70%	100%	100% / 80%
Prescription Drug – Generic	\$ 5 Co-pay	\$ 5 Co-pay	\$ 5 Co-pay	\$ 5 Co-pay
Formulary	\$ 5 Co-pay	\$10 Co-pay	\$10 Co-pay	\$10 Co-pay
Non-Formulary	\$5 Co-pay	\$10 Co-pay	\$15 Co-pay	\$15 Co-pay
Contraceptives	Covered / \$5 Co-pay	Covered	Covered	Covered
Mail Order /Days Supply per prescription	62 Days	90 Days	90 Days	90 Days
Generic	\$ 5 Co-pay	\$10 Co-pay	\$10 Co-pay	\$10 Co-pay
Formulary	\$ 5 Co-pay	\$20 Co-pay	\$20 Co-pay	\$20 Co-pay
Non-Formulary	\$5 Co-pay	\$20 Co-pay	\$30 Co-pay	\$30 Co-pay
Physical / Occupational Therapy	\$10 Co-pay	\$15 Co-pay / 70%	\$15 Co-pay / 70%	\$15 Co-pay / 80%
Annual Maximum	Up to 2 months or 30 visits per therapy, whichever is greater	60 visits	60 visits	60 visits
Speech Therapy	\$10 Co-pay Up to 2 months or 30 visits, whichever is greater	\$15 Co-pay / 70% 20 visits per benefit period	\$15 Co-pay / 70% 20 visits per benefit period	\$15 Co-pay / 80% 20 visits per benefit period
Mental Health (MH) and Substance Abuse (SA)				
Mental Health - In Patient	100%	100 % / 70%	100 % / 70%	100 % / 50%
Substance Abuse – In patient	100% One (1) admittance per year	100% / 70%	100 % / 50% Three (3) admissions per lifetime	100% / 50% Three (3) admissions per lifetime
MH & SA – In patient (Combined)	45 days per calendar year	30 days per benefit period	30 days per benefit period	30 days per benefit period
Mental Health - Outpatient	20 visits per year at \$10 Co-pay	\$15 Co-pay / 70% after deductible	\$15 Co-pay / 70% after deductible	\$15 Co-pay / 80% after deductible
Substance Abuse - Outpatient	100%	\$15 Co-pay / 70% after deductible	\$15 Co-pay / 50% after deductible	\$15 Co-pay / 50% after deductible
MH & SA – Outpatient (Combined)	Unlimited	50 visits per benefit period	50 visits per benefit period	50 visits per benefit period
Major Medical				
Single (deductible)	\$0	\$ 0 / \$ 250	\$ 0 / \$ 250	\$ 0 / \$ 250
Family (deductible)	\$0	\$ 0 / \$ 500	\$ 0 / \$ 500	\$ 0 / \$ 500
Single (Max Out-of-Pocket for Co-Insurance)	\$0	\$ 0 / \$2,250 (excludes deductible)	\$ 0 / \$ 2,250 (excludes deductible)	\$ 0 / \$ 2,000 (excludes deductible)
Family (Max Out-of-Pocket for Co-Insurance)	\$0	\$ 0 / \$4,500 (excludes deductible)	\$ 0 / \$ 4,500 (excludes deductible)	\$ 0 / \$ 4,000 (excludes deductible)
Lifetime Maximum	Unlimited	Unlimited / \$2,500,000	\$2,500,000	\$2,500,000
Dependent Age Limit	To Age 23 (if allowed as a federal tax exemption)	To Age 23 (if allowed as a federal tax exemption)	To Age 23 (if allowed as a federal tax exemption)	To Age 23 (if allowed as a federal tax exemption)
Special Feature-Durable Med. Equip.	100%	100% / 70%	100% / 70%	100% / 80%
Special Feature-Hospice	100%	100%	100%	100%
Special Feature-Skilled Nursing	100%	100% / 70%	100% / 70%	100% / 80%
Special Feature-Organ Transplant	100%	100% / 70% (if pre-authorized)	100% / 50% Separate \$1 Million Lifetime	100% / 50% Separate \$1 Million Lifetime
Infertility Services	70%--See Certificate for exclusions	Not Covered	Limited Coverage – See Certificate for exclusions	Not Covered

The above chart is a broad summary of the medical, dental, life and vision insurance provisions. Other plan provisions and limitations may apply. If there is a discrepancy between the plan document and this bulletin, the plan document will prevail. See Certificate of Coverage for details.

Dental Benefit Summary MetLife Insurance

Description	Basic		Enhanced	
Deductible	\$ 25 Individual / \$ 50 Family		\$ 25 Individual / \$ 50 Family	
Calendar Year Maximum	\$1,500 per person		\$ 1,000 per person	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Preventative Oral Examinations – 2 per year Prophylaxis (cleanings) – 2 per year Topical Fluoride Applications – to age 19 annually Bitewing X-rays – 2 per year Full Mouth X-rays – once every 36 months Space Maintainers for children under 19	80% of PDP Fee*	80% of R&C Fee**	80% of PDP Fee*	80% of R&C Fee**
Basic Fillings, Simple Extractions, Endodontics, Oral Surgery, Periodontics, General Anesthesia, Consultations	80% of PDP Fee*	80% of R&C Fee**	80% of PDP Fee*	80% of R&C Fee**
Major Bridges and Dentures – once every 5 years Inlays, Onlays & Crowns – once every 5 years Prosthetics (Fixed) – once every 5 years Crown Build-ups Veneers, Harmful Habit Appliance, Crown, Denture & Bridge Repair	20% of PDP Fee*	20% of R&C Fee**	80% of PDP Fee*	80% of R&C Fee**
Orthodontics – Child Only Dependents covered until age 19	20 % of PDP Fee*	20% of R&C Fee**	80% of PDP Fee*	80% of R&C Fee**
Orthodontia Lifetime Maximum	\$1,500 per person	\$ 1,500 per person	\$1,000 per person	\$1,000 per person
* PDP Fee refers to the negotiated fees that participating PDP dentists have agreed to accept as payment in full. ** Reasonable and Customary charge is based on the lesser: (1) the dentist's actual charge (2) the dentist's actual charge for the same or similar services or (3) the usual charge of most dentists in the same geographical area for the same or similar service as determined by MetLife.				

Vision Insurance Benefits

Spectera (United Optical Vision Plan) (Locals 279, 701, 777, 1199, non-union, CCAS & Administrators)	
Description	Employee Benefit/Co-pay
Examination One exam every 24 months for employees and dependents 19 years of age or older and once every 12 months for employees and dependents under age 19.	Exam \$0 Co-pay
Lenses / Frames One pair every 24 months for employees and dependents 19 years of age or older and once every 12 months for employees and dependents under age 19. Covered in full, including lens options such as tinted lenses and scratch-resistant coatings.	Single Vision \$45.00 Co-pay Standard Bifocals Standard Trifocals Lenticular or Aphakic Lens Frames on display
Contact Lenses One pair every 24 months for employees and dependents 19 years of age or older and once every 12 months for employees and dependents under age 19. In lieu of spectacle lenses and a frame, employees and dependents may choose contact lenses. Cosmetic and Medically Necessary contact lenses are covered in full (up to 4 boxes of disposable lenses.)	Contact lenses \$45.00 Co-pay
Union Eye Care (Locals 244, 407, and Building Trades)	
Examination One exam every 24 months for employees and dependents 19 years of age or older and once every 12 months for employees and dependents under age 19.	Regular spectacle exam: Full Coverage Contact lens exam: \$40.00 Allowance
Lenses / Frames One pair every 24 months for employees and dependents 19 years of age or older and one pair every 12 months for employees and dependents under age 19.	Single Vision Full Coverage Standard Bifocals Full Coverage Standard Trifocals Full Coverage Lenticular or Aphakic Lens Full Coverage Frames \$70.00 Allowance
Contact Lenses In lieu of frame and lenses, every 24 months for employees and dependents 19 years of age or older and every 12 months for employees and dependents under age 19.	\$100.00 Allowance
Discounts Discounts are given before your benefit is applied.	Frames 45%-50% off MSRP Lens products not listed 45% off retail MSRP Non prescription sunglasses 25% off retail MSRP Accessories 25% off retail MSRP Contact Lens Solution 25% off retail MSRP
Fees for Lens Options All fees are per pair.	Polycarbonate (polylite) Single Vision/ Multifocal \$25 / \$45 fee Scratch Resistant Coating \$14 fee Ultraviolet Absorptive Coating \$12 fee Solid Tint \$6 fee Gradient Tint \$10 fee Anti-Reflective Coating \$35 fee Photochromic (glass) Single Vision/ Bifocal \$15 / \$30 fee
When you are ready to use your benefit, simply call the Spectera/United Optical or Union Eye Care facility most convenient to you and make an appointment. Spectera/United Optical will request the employee's Social Security number and patient's date of birth to verify eligibility.	

Basic, Voluntary, Dependent and Portable Life Insurance Benefits Summary

Description	Consumer (an MMOH subsidiary) Life Insurance Company	
Basic Life Insurance	All <i>eligible</i> employees receive basic life insurance. The amount of coverage is based upon your position with the District.	
Late Enrollees or Increases in Coverage	If you do not enroll in Voluntary or Portable Life when you are first eligible as a new hire and wish to enroll at a later time or increase your amount during Open Enrollment, you will be required to complete an Evidence of Insurability Form. Premiums will be deducted from your paycheck beginning the month following approval by the insurance company.	
Enrolling in VOLUNTARY LIFE	You may purchase Voluntary Life in units. One (1) unit equals \$25,000. The maximum you may buy is six (6) units. The maximum life insurance volume that you may purchase is \$150,000.	
Employee Contributions for Voluntary Life Insurance	Age Schedule	Monthly Rate per \$25,000
	Under age 34	\$1.50
	35-39	1.75
	40-44	1.75
	45-49	2.75
	50-54	4.00
	55-59	6.25
	60-64	12.50
	65-69	18.50
	70 and over	26.75
Enrolling in PORTABLE LIFE	You may purchase Portable Life in units. One (1) unit equals \$10,000. The maximum you may buy is thirty (30) units. The maximum volume of insurance that you may purchase is \$300,000. You will be required to complete Evidence of Insurability.	
Employee Contributions for Portable Life Insurance	Age Schedule	Monthly Rate per \$10,000
	Under age 34	\$0.30
	35-39	0.40
	40-44	0.60
	45-49	1.00
	50-54	1.40
	55-59	2.40
	60-64	4.10
	65-69	6.40
	70 and over	10.00
Enrolling in DEPENDENT LIFE INSURANCE	Option I	Option II
	Spouse \$ 5,000 Child(ren) \$ 2,500 \$100 age 15 days to 6 months \$2,500 age 6 months to 21 years or age 23 if a full time student	Spouse \$ 10,000 Child(ren) \$ 5,000 \$100 age 15 days to 6 months \$5,000 age 6 months to 21 years or age 23 if a full time student
	<i>Option I monthly rate:</i> Family Unit \$ 1.75 Spouse Only \$ 1.35 Child(ren) Only \$ 0.40	<i>Option II monthly rate:</i> Family Unit \$ 3.50 Spouse Only \$ 2.70 Child(ren) Only \$ 0.80
Voluntary Insurance reduces by 50% at age 70 and terminates on retirement. If an employee is not actively at work on the date of any increase in benefits, the increase in coverage for that employee will not become effective until return to work.		
Beneficiary Designation – You can update your beneficiary data via the Internet during Open Enrollment. After Open Enrollment, beneficiary data can also be updated/changed at any other time by completing a beige Designation of Beneficiaries Card. Call Human Resources at (216) 574-8298 and request a new card.		
If you have not named a specific beneficiary, your death benefit will be paid to your estate. Instead of making death payment to your estate, the insurance company has the right to make payment to the surviving family members in the following order: 1) Legal Spouse; 2) Child or Children; 3) Mother or Father; 4) Sisters or Brothers.		

All covered services are subject to the conditions, exclusions, limitations, terms and provisions of Consumer Life Insurance Company.

Employee Assistance Program (EAP)

The District recognizes that from time to time each of us may experience difficulties that we may be unable to handle on our own. Help is provided through our Employee Assistance Program at no charge to you. This program is managed by the Center for Families and Children. The name of the program is EASE@WORK.

Call us.... We can help.

216-241-EASE (3273) or 1-800-521-3273

It is a confidential and voluntary employee assistance program provided free of charge to employees and their families.

EASE@WORK provides short-term counseling, referral services for child care and elder care needs, and legal and financial assistance. Our goals are to help you identify your problems, find solutions and plan for the future. We can assist you or your family members with any concerns, including:

*Marital Matters
Family Relationships
Work Problems*

*Legal Difficulties
Elder Care Issues
Child Care Needs*

*Anxiety & Depression
Personal Problems
Stress*

Flexible Spending Account

The Flexible Spending Account Plan details can be found at www.healthscopebenefits.com.

* The Dental/Vision Spending Account is for un-reimbursed Dental or Vision expenses you incur for the calendar year. Deductibles, co-pays, above reasonable and customary or costs above plan limits are eligible.

* The Dependent Care Spending Account helps you pay for child care costs or costs for the care of dependent adults unable to take care of themselves. *These accounts are NOT for reimbursement of medical/drug expenses.*

You decide how much to deposit. For the Dental/Vision Spending Account the minimum dollar amount is \$250.00 per calendar year and the maximum is \$3,000.00 per calendar year. For the Dependent Care Spending Account you are eligible to deposit up to \$5,000 per calendar year (married filing jointly), or \$2,500 if you are married and file separate income tax returns.

Reimbursements for Dependent Care expenses are subject to the following IRS requirements:

- ❖ The care must be necessary in order for you or your spouse (if married) to work or attend school full-time; or
- ❖ The amount to be reimbursed cannot be greater than your annual income or your spouse's annual income, whichever is lower; or
- ❖ If your spouse is a full-time student or is mentally or physically incapacitated, your spouse's assumed monthly income for reimbursement purposes is \$200 for one and \$400 for two or more eligible dependents.

The following rules apply:

If the dependent is a child:

- ❖ The child must be younger than 13;
- ❖ You must provide at least 50% of his/her financial responsibility;
- ❖ The care provider cannot be your dependent for tax purposes; and
- ❖ If the care is provided by a facility that cares for more than 6 children, the facility must be licensed.

If the dependent is an adult:

- ❖ The adult must be physically or mentally incapable of caring for himself/herself;
- ❖ You must provide at least 50% of his/her financial support; and the adult must spend at least 8 hours each day in your household.

Monthly Payroll Deductions

UNION/GROUP	CALENDAR YEAR 2008	
	Single	Family
Full Time Employees (assigned a minimum of 19 hours per week)*		
KAISER HMO (includes prescription drug plan)	\$ 0.00	\$ 10.00
AETNA (includes prescription drug plan)	\$ 15.00	\$ 30.00
MMO-SuperMed Select POS (includes prescription drug plan)	\$ 15.00	\$ 30.00
MMO-SuperMed Plus PPO (includes prescription drug plan)	\$ 15.00	\$ 30.00
Basic Dental	\$ 0.00	\$ 0.00
Enhanced Dental	\$ 11.94	\$ 38.80
Vision – Union Eye Care LOCALS 244, 407 & Building Trades	\$ 0.00	
Vision – Spectera LOCALS 279, 701, 777, 1199, non-union, CCAS & Administrators	\$0.00	

*Qualifying eligibility hours are based on District approved assignments and hours. Review your collective bargaining agreement for specific coverage and eligibility rules.

Customer Services

Medical Mutual of Ohio
1-800-228-6472
www.MedMutual.com

Kaiser HMO - PCP
Directory Information
1-800-686-7100

Pharmacy Network
Kaiser Mail Order
1-877-778-6695
www.kp.org

Aetna
1-877-238-6201

www.aetna.com

Union Eye Care
216-986-9700

www.unioneyecare.com

Spectera/United Optical
1-800-638-3120

www.spectera.com

Consumer Life Insurance
Company
1-866-925-2542
www.Consumerlife.com

MetLife Dental
1-800-942-0854

www.metlife.com

Enrollment Help/Inquiries:
Cleveland Metropolitan School
District Employee Benefits
Department, Room 500N
1380 East Sixth Street
Cleveland, OH 44114
Monday – Friday
9:00 am – 4:00 pm
216-574-8252/8164

OPEN ENROLLMENT
PERIOD IS NOVEMBER
1 – NOVEMBER 30,
2009. All changes must be
made by midnight on
November 30, 2009.

FREQUENTLY ASKED QUESTIONS

1. Can I enroll or make changes by completing a form?

No, you must enroll, make changes, add or delete via *Internet only* at www.cmsdjobs.com/esjobs/benefits.asp or by clicking on the Open Enrollment 2010 link at the District's home page (www.cmsdnet.net). Paper enrollment is not available.

2. If there is an error, how can I correct it?

Please refer to your Enrollment Instructions and Helpful Hints page. The last screen is the confirmation screen. Print out the confirmation page. This page confirms your elections and payroll deductions for 2010. Every time you enroll, a new confirmation page and confirmation number will be generated. If you do not receive a confirmation number, your elections will not be registered.

3. Will I receive confirmation of my selections?

Yes. A Confirmation Statement will be mailed to your home. Read it carefully and follow the instructions to correct any errors. The statement will be the last time you have an opportunity to provide correct information before your record is reported to the insurance carriers. Errors may delay the processing of your claims.

4. What major hospitals are under Aetna, Kaiser HMO and Medical Mutual of Ohio?

Aetna hospital network includes but is not limited to University Hospitals, Cleveland Clinic Foundation, Fairview, Hillcrest, Huron, Lakewood, Lutheran, Marymount, MetroHealth, Parma, Southwest General, St. Vincent Charity, St. John West Shore and others. Kaiser HMO has specific Kaiser Facilities to assist you. You must contact Kaiser HMO for the facility nearest you. Medical Mutual of Ohio hospital network includes but is not limited to the following hospitals: Cleveland Clinic Foundation, Fairview, Hillcrest, Huron, Lakewood, Lutheran, Marymount, MetroHealth, Parma, Southwest General, St. Vincent Charity and others. Please keep in mind that the hospitals in the network are subject to change at any time. For up-to-date information, you must contact your medical provider.

5. How do I find out if my current doctor or preferred medical facility is in the Kaiser HMO, Medical Mutual or Aetna networks?

Please go to www.kp.org, www.medmutual.com, or www.aetna.com for a list of network doctors and medical facilities.

6. What is a PCP?

A PCP is a Primary Care Physician. A primary care physician is responsible for providing or coordinating all of your medical care. A PCP is a network provider that specializes in family practice, general practice, internal medicine or pediatrics. If you choose to enroll in the Kaiser HMO or SuperMed Select POS plan, you must select a PCP for you and each eligible family member. Each family member may choose a different PCP based on his or her needs.

7. Will I receive a payment or refund if I Opt-Out of medical coverage?

Yes. You may be eligible provided that you submit proof of other medical coverage with your confirmation statement. You are eligible for a \$500 Opt-Out payment for declining the CMSD medical coverage. If you are eligible for family coverage but elect single coverage, you are eligible for a partial refund of \$250. If two married employees both work for the District, neither employee can Opt-Out of coverage and receive the cash payment. Opt-Out guidelines may vary per union agreement. Refer to your labor agreement for specific Opt-Out guidelines.

8. When will I receive the Opt-Out payment?

The first half of the payment is included in the second paycheck in April; the second half of the payment is included in the second paycheck in October.

9. What if I need to change my level of coverage in the middle of the year (single to family or family to single)?

Refer to your Enrollment Summary (Section 125 Plan) for information on an IRS-qualified change in status. Human Resources – Employee Benefits Department must be notified of the change **NO LATER THAN 30 DAYS** from the date of the change. You will be required to submit certain documents based on the type of change you are making.

10. What is the MetLife Preferred Dentist Program (PDP)?

The MetLife PDP is a Preferred Provider Organization, which allows you to choose a dentist at the time of treatment. You do not have to select a primary dentist and you do not need referrals for specialty care.

FREQUENTLY ASKED QUESTIONS Cont..

11. Do I need an identification card to use my dental benefits?

No. MetLife does not issue dental cards. Your dentist may verify eligibility by calling MetLife's toll free number at 1-800-942-0854.

12. Do I need an identification card to use my vision benefits?

No. Simply call a Spectera/United Optical or Union Eye Care facility and inform them that you are eligible for benefits under the District's group plan. You will need to provide your name, Social Security number, and the names and birth dates of any dependents who require treatment.

13. If both my spouse and I are employed by the District, what kind of coverage are we eligible for?

If two spouses work for the District, they can select either a single plan each or one family plan.

TERMS TO KNOW

Coinsurance – a cost-sharing method by which a health insurance plan pays a percentage of the provider's covered expense (often after a deductible is met) and the participant pays the rest. For example, the plan may pay 80% and the participant may pay 20%. In this case, the 20% is the participant's coinsurance.

Deductible – the amount of eligible expenses the participant may be required to pay each year before the plan begins to pay covered expenses.

Evidence of Insurability - proof of health, employment or other factors required before beginning or increasing insurance amount.

Generic Drug – a drug that does not have the trademark of the original manufacturer. It is chemically identical to and generally costs less than its brand name counterpart.

Health Maintenance Organization (HMO) – a network of hospitals, doctors and other medical providers who provide services through an HMO plan. There are no out-of-network benefits. Emergencies are reviewed individually.

Point-of-Service (POS) - a type of medical plan that generally provides a higher level of coverage and may require less paperwork, when the participant coordinates care through his or her primary care physician (PCP).

Preferred Dental Provider (PDP) - a MetLife dentist who has a contract with the plan to participate in the network. The contract includes provisions to accept the reasonable and customary charge or allowable amount for a given service as the full fee.

Preferred Provider Organization (PPO) – a network of medical care providers who have agreed to provide services at negotiated rates and have a contract with the plan.

Primary Care Physician (PCP) - a provider who has a contract with the plan to participate in the network. The contract includes provisions to accept the reasonable and customary charge or allowable amount for a given service as the full fee.

Employee Benefits – Spouse Eligibility*

Working spouse: ADD BACK to primary coverage:

As part of the 2007 negotiations between the Cleveland Metropolitan School District (CMSD) and its bargaining unions, during the November Open Enrollment period employee participants who removed their working spouses from CMSD primary coverage to secondary coverage may ADD BACK those spouses to CMSD primary coverage effective January 1, 2010. Spouses must be eligible to be added back to coverage in all other plan provisions. Coverage will begin January 1, 2010 and any claims after January 1, 2010 will be processed under the CMSD plan as primary.

If you are ADDING BACK your spouse, you must enter the online Open Enrollment program and enter your spouse as a dependent. Print the confirmation sheet for your records. A Confirmation Statement will be mailed to your home to confirm your change.

As part of the 2007 negotiations between the Cleveland Metropolitan School District (CMSD) and its bargaining unions, legal spouse eligibility may change. Below is a summary of the agreement:

Working spouse insurance coverage:

1. Effective January 1, 2008 and except as provided in Sections 7 and 8 below, if a CMSD employee's **spouse** is eligible to participate (either as a current employee or retiree) in group health insurance and/or prescription drug insurance sponsored by his/her employer or retirement plan provider, the **spouse** must enroll in such employer or retirement plan sponsored group insurance coverage(s). The spouse is not required to enroll in family coverage in his/her employer or retirement plan sponsored group insurance coverage(s); nor is the spouse required to cover children.
2. Upon the spouse's enrollment in any such employer or retirement plan, that plan will provide primary coverage for the spouse and the District's plan will provide secondary coverage so long as the CMSD employee is enrolled in the District's family coverage.
3. During the open enrollment period, every CMSD employee who has family coverage which includes a spouse who participates in the District's group health insurance coverage and/or prescription drug insurance coverage shall complete and submit to the District a written declaration verifying whether his/her spouse is eligible to and shall participate in group health insurance coverage and/or prescription drug insurance coverage sponsored by the spouse's employer or retirement plan provider, effective no later than January 1, 2008.
4. Any CMSD employee whose spouse becomes eligible for any employer/retirement plan sponsored coverage after the open enrollment period shall notify the District within thirty days.
5. If a CMSD employee submits false information about his/her spouse or fails to timely notify the District of a change in the spouse's eligibility for employer/retirement plan sponsored group health and/or prescription drug insurance coverage, the employee may be subject to disciplinary action up to and including termination. In addition, the CMSD employee shall be personally liable to the District for reimbursement of the costs of benefits and expenses. The CMSD employee spouse shall also be immediately terminated from the District's group health insurance and/or prescription drug insurance coverage.
6. Any spouse, who fails to enroll in any group insurance coverage sponsored by his/her employer or retirement plan provider, as required by this section, shall be ineligible for benefits under the group insurance coverage sponsored by the District.
7. Any CMSD employee whose spouse is a retired CMSD employee with at least 10 years of full-time service with CMSD and whose spouse is eligible for STRS or SERS health care and/or prescription benefits may elect to cover the spouse as primary. The retired spouse does not have to enroll in the STRS or SERS health care and/or prescription plan. However, if the retired spouse should become employed, he/she is required to enroll in his/her employer's health care and/or prescription plan for single coverage as provided in items 3-4.
8. Any CMSD employee who selects family coverage provided by Kaiser shall not be subject to the provisions in items 1-7.

*Refer to your labor agreement.

The primary goal of the Cleveland Metropolitan School District is to become a premier school District in the United States of America.

Dr. Eugene T.W. Sanders, Ph.D.
Chief Executive Officer

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1380 East Sixth Street • Cleveland, Ohio 44114 • 216.574.8000
www.cmsdnet.net

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