THE CITY OF
COLUMBUS
ANDREW J. GINTHER, MAYOR

DEPARTMENT OF
HUMAN RESOURCES

High Deductible Health Plan (HDHP) Open Enrollment 2025:

Open Enrollment is October 28th - November 30th, 2024.

Review the enclosed information to learn more about:

- HDHP Medical with Health Savings Account
- Clinical Programs
- Pharmacy
- Dental Care
- Vision Care
- Basic Life Insurance - Beneficiary Designation
- Dayforce Employee Self Services - Open Enrollment Navigation Tips

Reminder! Health Savings Account (HSA).

You need to make an HSA election each year in the Dayforce Enrollment System. Your previous plan year contributions, if applicable, will not automatically rollover. An HSA is a personal bank account that YOU own, and open with CME Federal Credit Union. Account must be opened by **December 31, 2024**.

Wellness Programming - RALLY.

Whether using MyUHC.com or logging in from RALLY, you can access your wellness programming, incented challenges, and resources just by registering and logging in. Learn more about your RALLY resources later in this booklet.

Are you tuned into the Wellness Wednesday newsletter and Five on Friday videos?

To help you with making better decisions, locating information and resources more rapidly you can read our **Wellness Wednesday weekly newsletter** or tune in to our **Five on Friday YouTube videos**.

United Healthcare

HDHP with HSA: General Information

If you have always taken the PPO plan, having the High Deductible Health Plan (HDHP) with a Health Savings Account (HSA) plan may seem confusing. There are many myths about HDHP designs and how they work.

"Are HDHP designs only good for healthy, singles or families with no kids?"

No, an HDHP is not only for the healthy, singles, or families with no kids. They work for all people regardless of their age, health, income, marital status or having dependents. HDHPs offer lower monthly premiums, the same freedom to choose doctors and specialists without a referral, and an out-of-pocket maximum limit that protects you from the costs of a major illness and prescription expenses.

"How can my HDHP cost me less when I have a higher deductible where I would be paying hundreds of dollars for doctor visits and prescription drugs?"

With an HDHP, you are not spending your money on benefits you may not need or use. With a lower monthly premium, you can put your premium savings tax-free into your health savings account (HSA) and use them to pay your deductible.

Remember, you don't have to pay anything for in-network routine preventive care visits, and you are protected by an out-of-pocket maximum limit. Once you reach your out-of-pocket maximum, you don't have to pay anything for covered services and prescriptions the rest of the year.

"Will I lose my HSA dollars if I don't use them by the end of the year?"

No, you won't lose your HSA dollars. There's no "use it or lose it" rule with HSA accounts. Your HSA funds can be carried over from year to year without restrictions.

You own your HSA. You have complete control of when you use the money. You could use it to pay for prescriptions and doctor visits, or you could save your HSA dollars so they can continue to grow tax-free. It's your money, it's your account – to keep even if you change jobs, health plans, or retire.

"HDHPs are hard to understand. Can you make it simpler for me?"

Just remember three simple steps:

1.Your health plan has a deductible You pay until you reach your deductible, then 20% (10% for FOP) until you reach your out-of-pocket maximum. You can use your HSA to help pay it.

2.You are protected with an out-of-pocket maximum Once you reach your out-of-pocket maximum, you are done paying. The health plan pays 100% of covered services for rest of the year, assuming you continue to use in-network providers.

3. Preventive care is paid at 100% Remember, the plan pays 100% for your preventive care when you use in-network doctors.

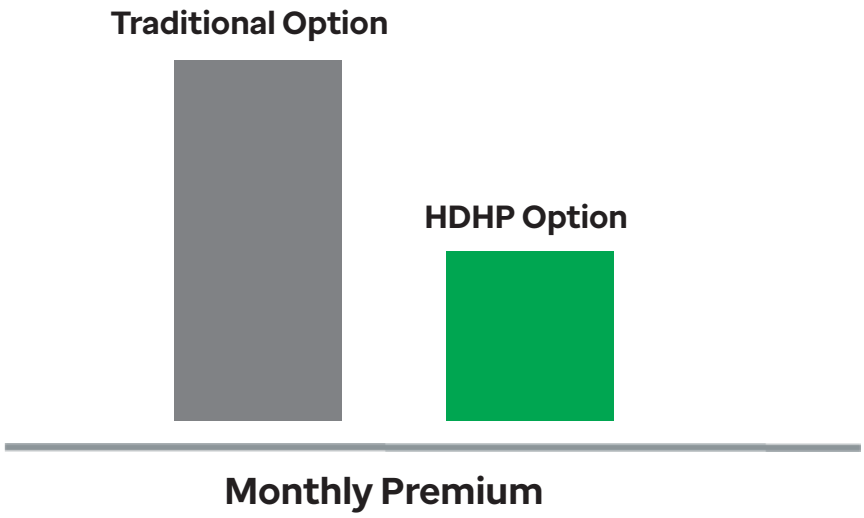
UnitedHealthcare Medical Plans

AFSCME 1632 & 2191, CWA, FOP, IAFF, OLC, and HACP/MCP Ordinance Groups' employees have two plans to choose from each year.

- **Qualified High Deductible Health Plan** (HDHP) with a **Health Savings Account** (HSA). If you wish to elect HDHP, you must do so during THIS open enrollment or
- **Traditional PPO Plan** – annual open enrollment for the traditional PPO is held in February. If you are currently enrolled in the HDHP with HSA and wish to switch back to the traditional PPO plan, you must actively end the HDHP and enroll in the PPO plan during this open enrollment window.

Premium Comparison

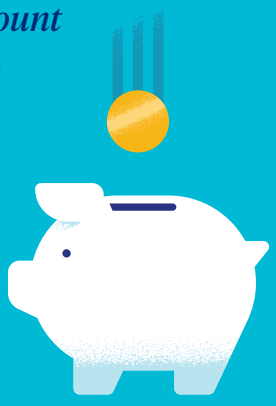
The HDHP has a lower employee contribution premium than the Traditional PPO Plan.



Premium contribution savings between PPO & HDHP

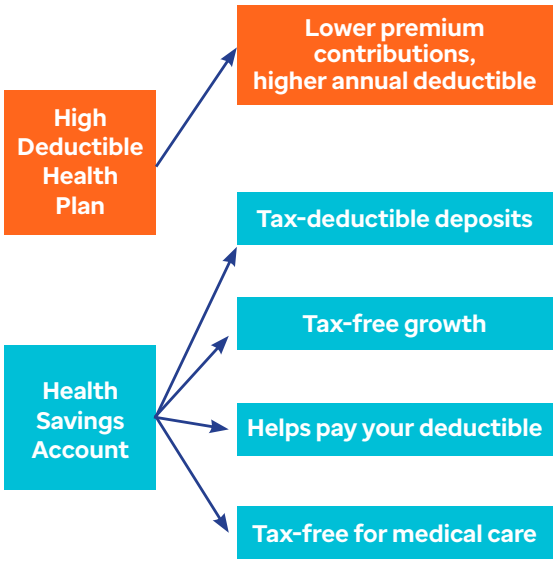
- **For Single Coverage**, the HDHP enrollee will pay $600 less in annual premium contributions ($50 less per month)
- **For Family Coverage**, the HDHP enrollee will pay $1,560 less in annual premium contributions ($130 less per month)

Your per pay contribution is less if you choose the HDHP, which adds up to BIG savings. Consider using your monthly premium savings per pay and depositing those funds into your Health Savings Account with CME to increase healthcare savings!



How does an HDHP with HSA work?

An HDHP with HSA has two parts, first is your HDHP medical plan that covers all the same services that the Traditional PPO plan offers. The only difference is premium contribution and higher deductible without the flat-dollar copay you pay for prescription drug purchases.



The second part is the Health Savings Account. The HSA is owned by the employee who can deposit money into the account in addition to the money the City contributes. Employer deposits are made in January and July. The money is typically spent to help pay for your deductible, but some people use it to save money for future medical expenses. Your money can grow interest, and even the interest is tax free. The money is federal tax free if it's spent on a qualified medical expense. Please see **irs.gov/publications/p502** for more information on qualified medical expenses.

HSA Bank Account:

What do I need to know?

You can open a health savings bank account, a personal account you own for medical needs – even into retirement. No "use it or lose it."

- You or others make deposits to grow the account, not to exceed the annual IRS limits.
- Money you spend from your HSA is for qualified medical expenses.
- You can even earn interest on your balance, see a CME representative for more details or log on to **CMEFCU.org**.

Building a Balance in my HSA Bank Account:

Where does the money come from?

The city will make the employer deposit into your HSA bank account semi-annually in January and July each plan year.

- $600 for single coverage
- $1200 for family coverage

Participants in the HDHP will pay lower monthly premium contributions.

Healthcare consumers should consider depositing the premium savings into an HSA bank account to increase savings potential.

- $50 per month for single coverage or $600 annually.
- $130 per month for family coverage or $1560 annually.

The example below is a chart showing the potential savings by simply depositing the premium savings with the employer annual deposit and with no additional monies out of pocket for the participant.

	Single	Family
Annual premium savings if you take the HDHP/HSA option	$600	$1,560
City of Columbus Annual HSA Contribution	$600	$1,200
Total HSA Contribution	$1,200	$2,760

Keep in mind the annual limits for single and family coverage. The participant can still contribute up to the IRS maximums each year.

Health Savings Bank Account

What are the 2025 contribution limits?
*Meaning: **how much money can I put away?***

Amount of Funding

The IRS determines how much you can fund annually. There is no limit on how much money can accumulate, the IRS only limits how much can be deposited each year.

Contribution Rules

Consumers can contribute up to the annual maximum amount as determined by the IRS. Maximum contribution amounts for 2025 are $4,300 for single coverage and $8,550 for family coverage.

Additional Funding

Those 55 years of age or older, but not yet entitled to Medicare benefits, can fund an additional $1,000 per year “catch-up” contribution. If your spouse is 55 or older, they can open an HSA bank account and deposit a $1,000 “catch-up” contribution in addition to these amounts.

Deposits cannot exceed the annual IRS limits for coverage level.

Making HSA Deposits

How do I get the money into my HSA bank account?

Payroll deduction

Contribute through payroll deduction, up to the annual IRS maximum limit as determined by your coverage level. Enter Dayforce, complete the annual open enrollment election and enter your annual HSA contribution amount after you elect the HDHP for plan year 2025. You must elect both the HDHP and the HSA during the November Open Enrollment period. Dayforce will have already taken into account your employer contribution amount.

Mail a Check

You can write a check out of a personal checking or savings account to fund your HSA account. Deposit additional dollars into your account by April 15 of the current year in order to realize tax savings for the prior year (applicable for members only who took the HSA option in 2024.)

e-Contribute

Contact CME Federal Credit Union to set up an electronic transfer from an existing CME account or from an account at another financial institution. See your CME Federal Credit Union representative for more details, or go to **CMEFCU.org**.

Paying for Non-Qualified Expenses

What happens if I spend the money on a non-qualified medical expense, like a new car?

Any HSA funds used for purposes other than to pay for qualified medical expenses are:

- Taxable as income
- Subject to a 20% tax penalty*

** The 20% tax penalty does not apply to account holders aged 65 and older, those who become disabled or enroll in Medicare.*

***What does this mean?** It means be thoughtful about what your HSA dollars are used for, so you don't have to pay taxes!*

HSA Bank Account Eligibility

Because you don't pay taxes on the money, the IRS has rules about who can open the bank account.

You are eligible to open and contribute to an HSA if:

- You are covered by an eligible high deductible health plan (HDHP) – which means you can't take the Traditional PPO plan and open an HSA account
- You are not covered by any other traditional health plan that is not a high deductible health plan (vision & dental is permissible)
- You are not entitled to Medicare, TRICARE or TRICARE for Life
- You have not received VA benefits within the past three months unless the care was for a service-related disability
- You are not claimed as a dependent on someone else's tax return
- You are not covered by a Health Care Flexible Savings Account (FSA)

HSA Qualified Medical Expenses

What does the IRS consider a qualified medical expense?
Meaning: ***"what can I spend the money on?"***

- Medical and pharmacy deductibles and coinsurance
- Dental and vision care services and products
- Use HSA dollars to pay for qualified medical expenses for your spouse or eligible dependents. *(Please note that the IRS considers a dependent eligible until age 24).* So, although you can keep dependent children on the medical plan until age 26, you can only spend HSA dollars on their care until age 24.
- Health coverage while receiving unemployment benefits
- COBRA continuation coverage
- Qualified long-term care
- Medicare premiums and out-of-pocket expenses

For a complete list of qualified medical expenses, visit **irs.gov/publications/p502**

Any money you take out of your HSA for qualified medical expenses is income-tax free.

Opening a CME Federal Credit Union HSA Bank Account

How do I open my HSA bank account?

Take advantage of the easy online account opening process:

- Open anytime before December 31, 2024; 2025 account funding is available in January.
- Complete step-by-step details provided for Current Members and New Members, later in this guide.
- Employee will receive electronic documents for e-signing from a secure site called DOCUSIGN.
- Cards will arrive 7-10 business days from completion of DOCUSIGN in an unmarked envelope for security purposes. PIN will arrive separately.
- Option to open in local branches available, if preferred, or contact CME toll-free at **888-224-3108**.
- The HSA is not considered active without current mailing address, phone number and returned DOCUSIGN, it is imperative you return the DOCUSIGN form immediately after opening the account.

Paying for Services

Do I get a debit card?

Your HSA Debit Card will be mailed to your home within 7-10 business days of your account complete activation. A PIN will be sent separately.

Open Your HSA Bank Account Today!

Pages 60-61 *have complete instructions for how* ***new*** *and* ***existing*** *CME Federal Credit Union Members can open an HSA Bank Account.*

2025 Open Enrollment: Comparison of AFSCME 1632 & 2191, CWA, OLC and HACP/MCP Plan Designs

	Traditional PPO	HDHP with HSA
Annual Deductible		
In-Network	$300 single/$600 family*	$1,650 single/$3,300 family**
Non-Network	$800 single/$1,600 family*	$3,300 single/$6,600 family**
Co-insurance		
In-Network	20% after deductible is met	20% after deductible is met
Non-Network	40% after deductible is met	40% after deductible is met
Out-of-Pocket Maximum (OOPM)		
In-Network	$700 single/$1,200 family*	$3,000 single/$6,000 family**
Non-Network	$1,600 single/$3,200 family*	$6,000 single/$9,000 family**
Office Visit Co-pay		
Primary Care	$20 co-pay	20% after deductible is met
Specialist	$30 co-pay	20% after deductible is met
Hospital Inpatient Stay		
In-Network	20% after deductible is met	20% after deductible is met
Non-Network	40% after deductible is met	40% after deductible is met
Outpatient Surgery		
In-Network	20% after deductible is met	20% after deductible is met
Non-Network	40% after deductible is met	40% after deductible is met
Emergency Room Co-pay		
In-Network (for OLC)	$75 co-pay, 20% after co-pay and deductible (co-pay waived if admitted)	20% after deductible is met
In-Network (for AFSCME 1632 & 2191, CWA, HACP/MCP)	$150 co-pay, 20% after co-pay and deductible (co-pay waived if admitted)	20% after deductible is met
Non-Network	same as in-network	20% after deductible is met
Urgent Care Co-pay		
In-Network (for OLC)	$30 co-pay, 20% after co-pay and deductible	20% after deductible is met
In-Network (for AFSCME 1632 & 2191, CWA, HACP/MCP)	$30 co-pay	20% after deductible is met
Non-Network	$30 co-pay, 40% after co-pay and deductible	40% after deductible is met
Lifetime Maximum	No maximum	No maximum
Rx Co-pays	Retail/Mail	
Tier 1	$5/$12.50	20% after deductible is met
Tier 2	$15/$25	20% after deductible is met
Tier 3/ Dispense as Written	$30/$60	20% after deductible is met
Rx OOP Max	$2,000 single/$4,000 family	Medical and Rx Combined

* PPO Family Deductible and OOPM are EMBEDDED ** HDHP Family Deductible and OOPM are NON-EMBEDDED

2025 Open Enrollment:
Comparison of FOP Plan Designs

	Traditional PPO	HDHP with HSA
Annual Deductible		
In-Network	$300 single/$600 family*	$1,650 single/$3,300 family**
Non-Network	$800 single/$1,600 family*	$3,300 single/$6,600 family**
Co-insurance		
In-Network	90%/10% after deductible is met	90%/10% after deductible is met
Non-Network	60%/40% after deductible is met	60%/40% after deductible is met
Out-of-Pocket Maximum (OOPM)		
In-Network	$700 single/$1,200 family	$3,000 single/$6,000 family
Non-Network	$1,600 single/$3,200 family	$6,000 single/$9,000 family
Office Visit Co-pay		
Primary Care	10% after deductible is met	10% after deductible is met
Specialist	10% after deductible is met	40% after deductible is met
Hospital Inpatient Stay		
In-Network	10% after deductible is met	10% after deductible is met
Non-Network	40% after deductible is met	40% after deductible is met
Outpatient Surgery		
In-Network	10% after deductible is met	10% after deductible is met
Non-Network	40% after deductible is met	40% after deductible is met
Emergency Room Co-pay		
In-Network	10% after deductible is met	10% after deductible is met
Non-Network	same as in-network	same as in-network
Urgent Care Co-pay		
In-Network	10% after deductible is met	10% after deductible is met
Non-Network	40% after deductible is met	40% after deductible is met
Lifetime Maximum	No maximum	No maximum
Pre-Notification Penalty	Benefits reduced to 50% of eligible expenses	Benefits reduced to 50% of eligible expenses
Rx Co-pays	Retail/Mail	Retail/Mail
Tier 1	$5/$12.50	10% after Deductible is met
Tier 2	$15/$25	10% after Deductible is met
Tier 3/ Dispense as Written	$30/$60	10% after Deductible is met
Rx Copays Accumulate	Yes	Yes
Rx OOP Max	$2,000 single/$4,000 family	Medical and Rx Combined

* PPO Family Deductible and OOPM are EMBEDDED ** HDHP Family Deductible and OOPM are NON-EMBEDDED

2025 Open Enrollment:
Comparison of IAFF Plan Designs

	Traditional PPO	HDHP with HSA
Annual Deductible		
In-Network	$300 single/$600 family*	$1,650 single/$3,300 family**
Non-Network	$800 single/$1,600 family*	$3,300 single/$6,600 family**
Co-Insurance		
In-Network	20% after Deductible	20% after Deductible
Non-Network	40% after Deductible	40% after Deductible
Out-of-Pocket Maximum (OOPM)		
In-Network	$700 single/$1,200 family*	$3,000 single/$6,000 family**
Non-Network	$1,600 single/$3,200 family*	$6,000 single/$9,000 family**
Office Visit		
In-Network	20% after Deductible	20% after Deductible
Non-Network	40% after Deductible	40% after Deductible
Hospital In-Patient Stay		
In-Network	20% after Deductible	20% after Deductible
Non-Network	40% after Deductible	40% after Deductible
Outpatient Surgery		
In-Network	20% after Deductible	20% after Deductible
Non-Network	40% after Deductible	40% after Deductible
Emergency Room		
In-Network	20% after Deductible	20% after Deductible
Non-Network	20% after Deductible	20% after Deductible
Urgent Care		
In-Network	20% after Deductible	20% after Deductible
Non-Network	40% after Deductible	40% after Deductible
Lifetime Maximum	No Maximum	No Maximum
Rx Co-pays	Retail/Mail	
Tier 1	$5/$12.50	20% after Deductible is met
Tier 2	$15/$25	20% after Deductible is met
Tier 3/ Dispense as Written	$30/$60	20% after Deductible is met
Rx OOP Max	$2,000 single/$4,000 family	Medical and Rx Combined

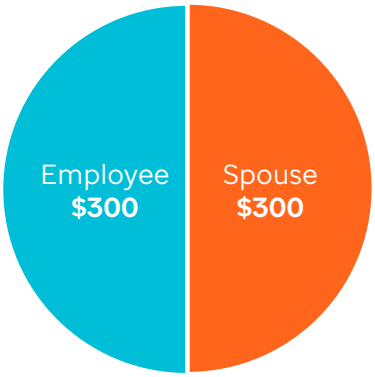
* PPO Family Deductible and OOPM are EMBEDDED

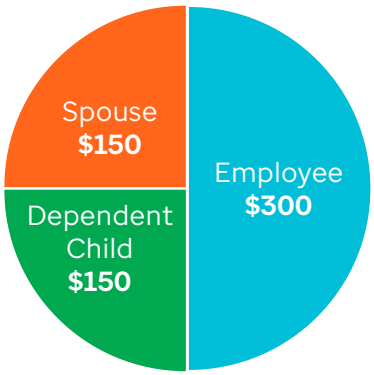
** HDHP Family Deductible and OOPM are NON-EMBEDDED

Embedded vs Non-Embedded Deductible

What does "Embedded" deductible mean?

Traditional PPO Plan:
$300 Individual deductible
$600 Family deductible

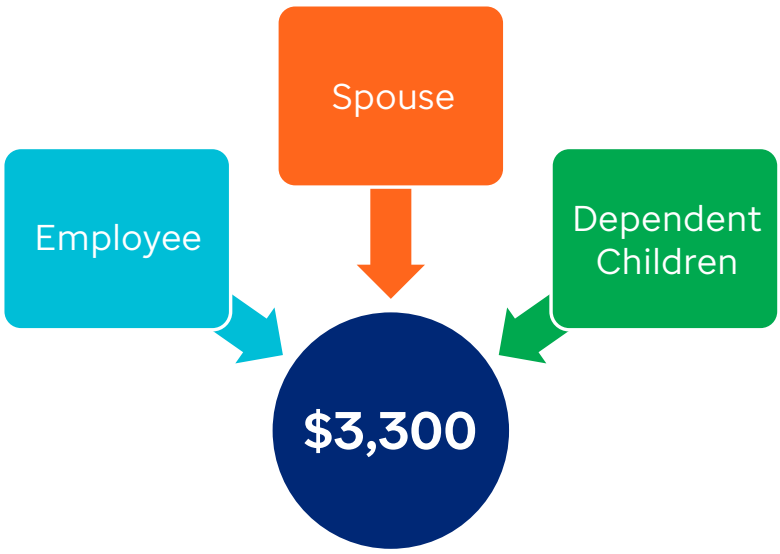




An embedded deductible means nobody in the family will pay more than the single deductible. The PPO plan has a $600 family deductible which could be met by the employee and spouse both meeting $300, or could be met by a combination of family members totaling $600. Just like the PPO/traditional deductible, the out-of-pocket maximum is also embedded.

What does "non-Embedded" deductible mean?

High Deductible Health Plan:
$3,300 Family deductible



A non-embedded deductible means that any one person in the family could meet the entire family deductible. The HDHP has a $3,300 family deductible that can be satisfied by a single person, or the combination of everyone in the family totaling $3,300. Just like the HDHP deductible, the HDHP out-of-pocket maximum is also non-embedded.

Choosing Between the HDHP and PPO Plans

What do I need to think about when I make the decision?

When choosing your plan for 2025, you need to consider the amount of money that you pay in monthly premium, the plan design and what works for you and your family.

A side-by-side comparison of the plans' in-network benefits:

	HDHP	PPO
Medical Out-of-Pocket Maximum	Combined Medical & Pharmacy Out-of-Pocket Max for the HDHP Plan Employee Only: $3,000 Family: $6,000	Employee Only: $700 Family: $1,200
Pharmacy Out-of-Pocket Maximum		Employee Only: $2,000 Family: $4,000
Total Out-of-Pocket Maximum	Employee Only: $3,000 Family: $6,000	Employee Only: $2,700 Family: $5,200
City of Columbus' Contribution into the HSA Bank Account	Employee Only: $600 Family: $1,200	N/A
Annualized difference in the premium between the HDHP and PPO Options	Employee Only will pay $600 LESS in premium on the HDHP Family will pay $1,560 LESS in premium on the HDHP	Employee Only will pay $600 MORE in premium on the PPO Family will pay $1,560 MORE in premium on the PPO

How can I research medical care?

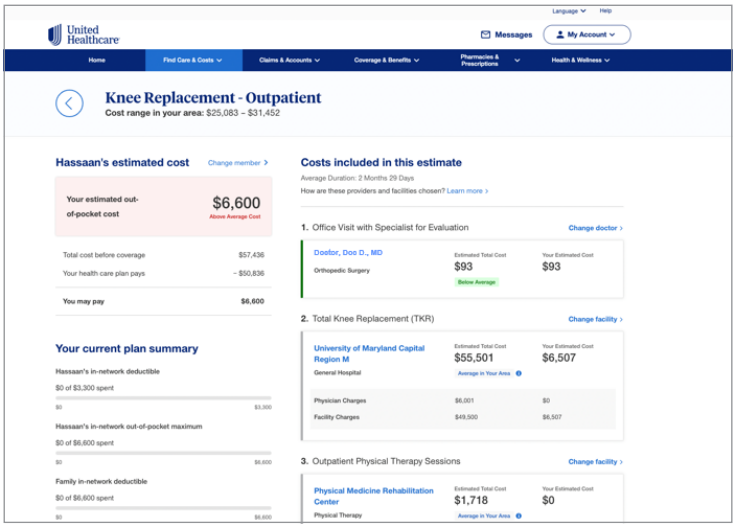
When you're deciding where to go for care, look at cost, as well as quality and convenience. Often you can get the care you need — and save money at the same time. Just go to ***myuhc.com*** *to:*

Find and compare costs.

Compare costs for Rx, providers, and services in your network, including doctors, behavioral health resources, hospitals, office visits, labs, convenience and urgent care clinics and more. For minor health concerns, you can register for a Virtual Visit and pay $50 or less to talk to a doctor on your phone or computer.

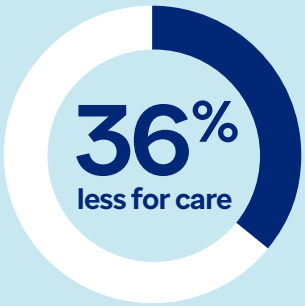
Get personalized estimates.

Before your visit, you can generate an out-of-pocket estimate based on your specific health plan status.



Did you know?

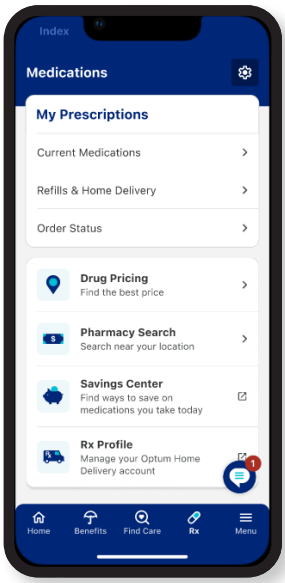
You could pay an average of 36 percent less for care by checking your costs on myuhc.com.

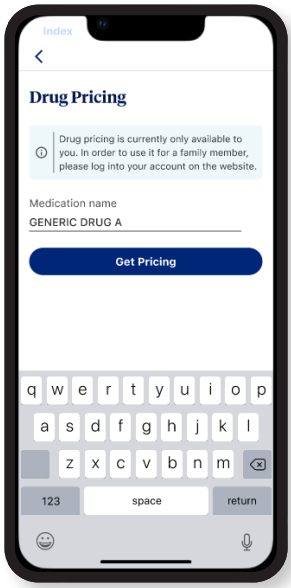


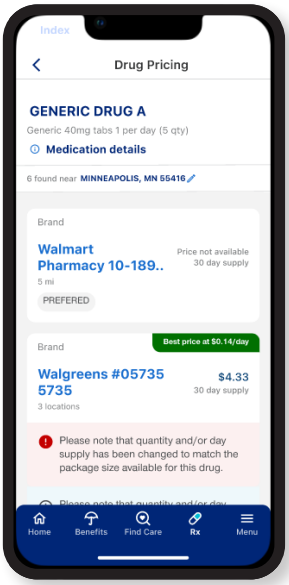
It's all in one easy-to-use search tool!

How can I find out the cost of my medications?

*Use the **myuhc.com or UHC App** to research the cost of your prescriptions, order refills, locate a pharmacy and more!*







Key features of the *myuhc.com or UHC App*:

- Refill, renew or transfer
- Adherence Text Reminders
- Pharmacy Locator
- Order history and claims detail
- Family and Caregiver Management

It's important to know and understand the true cost of your medications before making the trip to the pharmacy, ***especially for people considering a move to the HDHP option.***

Log onto the myuhc.com or the UHC app today to determine the true cost of your medication, and to see if there is a lower cost option available. If there is, call your physician to see if it's appropriate for you.

Take advantage of the **"$4 lists"** or drug pricing apps on your smartphone that are available through many retailers.

Pharmacy: Prior Authorization Includes Notification and Medical Necessity

Pharmacy costs are on the rise. And with medication efficacy and safety in sharp focus, it is vital that members get appropriate clinical care, including the right medication.

With the UnitedHealthcare® Prior Authorization program, the member must meet specific clinical requirements before the medication is approved for coverage. This helps ensure that the coverage provided is for the right medication, the right dose and the right duration of therapy.

When evaluating drug costs, prior authorization programs are in place for drugs representing 40% of total drug costs but only impact less than 5% of all claims.

Obtaining prior authorization before a medication is covered:

- Promotes safe and effective medication use.
- Helps members save on pharmacy costs.

Two ways that UnitedHealthcare utilizes clinical requirements to determine coverage approval is through the Notification program and the Medical Necessity program.

1. **Notification** – The provider needs to provide diagnosis information first, which helps to determine if the prescription meets the plan benefit coverage and approved U.S. Food and Drug Administration (FDA) requirements for medication and diagnosis.

2. **Medical Necessity** – Specific conditions must be met for a medication to be deemed medically necessary, including:
   - Is the medication clinically appropriate?
   - Is the medication appropriate for the diagnosis?
   - Is the medication cost effective?

How do we determine prior authorization programs?

An expert team of clinical pharmacists develop and maintain our Prior Authorization program with oversight from the UnitedHealthcare National Pharmacy & Therapeutics Committee. This committee consists of expert physicians and pharmacists who specialize in various therapeutic areas. The Prior Authorization program is based on nationally recognized clinical practice guidelines, U.S. Food and Drug Administration (FDA)-approved product labeling, published clinical literature and input from active health care practitioners.

This rigorous, evidence-based review ensures that coverage is based on approved or proven use of medications and includes:

- Diagnosis.
- Dose and duration.
- Genetic testing as appropriate.
- Other clinical information.

Pharmacy: Prior Authorization, *continued*

Innovative programs and tools

To speed and simplify the prior authorization process, we offer additional programs including:

Expiring Prior Authorization program — Proactively notifies a physician during the standard medication renewal process to extend the authorization for continued refills or discontinue the medication if clinically appropriate. This helps members stay adherent to their treatment.

Expiring Prior Authorization program response rate:

85% for specialty medications.

75% for non-specialty medications.

70–80% expiring prior authorization renewal/approval rate.

Medical Diagnosis to Script (Dx2Rx) program — Streamlines prior authorization requirements by conducting a real-time check to automatically find a member's diagnosis in claims history. For a new diagnosis, the pharmacist can enter the prescriber-provided diagnosis code. This helps members start taking their medication as soon as possible.

Medical Diagnosis to Script program:

Avoids 30–40% of prior authorizations with medical diagnosis match.

PreCheck MyScript — A sophisticated tool that gives providers real-time access into member pricing, lower-cost alternatives and prescription drug list placement. Using patient-specific benefit information within the prescriber's electronic medical records helps providers prescribe the appropriate medication for each member. Prescribers can use this tool to initiate the Prior Authorization process when necessary.

PreCheck MyScript:

>20% of all transactions with an alternative resulted in a drug change.

>30% prior authorizations avoided or initiated.

UHC® App: Your critical health information in the palm of your hand

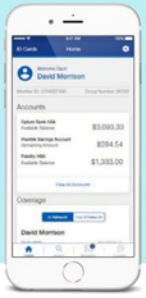
The more you know about your health care, the better you can manage your health and money. The UHC® mobile app gives you access to all the information you need to manage health care for your family — just like on myuhc.com®.

With the free UnitedHealthcare UHC mobile app, access your benefits and coverage information, manage your accounts, and more:

- Get health care cost estimates for specific treatments, procedures and medications
- Review hospital quality and safety data
- Receive real-time status on account balances, deductibles and out-of-pocket spending
- Find physicians and facilities nearby
- Track and manage claims
- Pay providers
- Access your ID card

Get on-the-go access:

The UHC App puts your health plan at your fingertips. Download it for free today to use the myuhc.com features listed here. Plus, view your digital ID card, find nearby care and more.



Don't delay. Know more today.

You can download the free UHC app through the Apple® App Store℠ or Google Play™ store for Android™ devices.

The City of Columbus Health Engagement Nurses can help you achieve your health goals!

Your Health Engagement Nurses Wendy & Whitney

are available to help you and your family make better health care decisions, refer you to appropriate wellness programs and services, and demonstrate how to navigate UnitedHealthcare tools and resources.

All information shared with the Health Engagement Nurses is **100% confidential**

Contact the City of Columbus Health Engagement Nurses at:

Office Phone
614-645-NURS (6877)

Email
nurse@columbus.gov

Health Engagement Nurses
Wendy Karcher RN and
Whitney Smith RN
nurse@columbus.gov
614-645-NURS

Quality care, done virtually

See a primary care provider or get same-day urgent care on your phone, tablet or computer

With virtual care through your UnitedHealthcare plan, get care any time.

Using your smartphone or other connected device,* like a tablet or a computer, you can access virtual primary and urgent care.

To schedule a virtual primary care appointment or access urgent care through 24/7 Virtual Visits, just download the **UnitedHealthcare® app** or visit **myuhc.com/virtualcare**.

What kind of virtual care might be right for you?

Virtual primary care:

- Annual wellness visits
- Regular follow-ups for conditions like asthma, diabetes, etc.
- Lab tests and preventive screenings
- Referrals to quality network specialists
- Medication review and prescriptions, if needed**
- Cost aligns with PCP benefit

24/7 Virtual Visits:

- Non-emergency care for common health issues like the flu, fevers, sore throats, etc.
- Non-emergency care for sudden health issues like pinkeye, migraines, back pain, even allergies and anxiety
- Prescription refills, if needed**
- Cost aligns with 24/7 Virtual Visits benefit

Scan the QR code to access your virtual care options

*Data rates may apply.

**Certain prescriptions may not be available, and other restrictions may apply.

Understanding Preventive Care

Maintaining or improving your health with regular preventive care, along with following the advice of your doctor, may help you stay healthy. Preventive care focuses on evaluating your current health status when you are symptom free and helps you avoid more serious health conditions.

Even if you're in the best shape of your life, a serious condition with no signs or symptoms may put your health at risk. Routine checkups and screenings can help you avoid serious health problems, allowing you and your doctor to work as a team to manage your overall health.

Preventive or not?

When you visit your doctor, the services you receive will be considered either preventive or non-preventive subject to the terms of your benefit plan.

At **uhc.com/health-and-wellness/preventive-care** you can find your age and gender-specific preventive care recommendations. You can download, e-mail and print this information to review with your doctor to make health decisions about your lifestyle and daily habits to help you live a healthier life. You can also set up helpful preventive health email reminders.

For more information about preventive care services that may be right for you visit ***www.uhc.com/health-and-wellness/preventive-care***

Medical Necessity

Important information about medical necessity with your UnitedHealthcare medical benefit plan.

UnitedHealthcare is committed to helping people live healthier lives. One way we do this is by promoting high-quality and affordable care. ***Medical Necessity*** *is aimed at promoting care that is medically appropriate and proven effective.*

This document is intended only to highlight this important component of your medical plan. You should refer to your Summary Plan Description for a complete listing of services, limitations, exclusions and a description of all the terms and conditions of coverage.

Your coverage documents tell you which services are covered benefits under your benefit plan and which services require Prior Authorization.

Prior Authorization

Within your coverage documents you will find a plan requirement called Prior Authorization. Prior Authorization is the process of determining benefit coverage prior to certain services being rendered. A coverage determination is made based on the requirements outlined in your medical plan. This process may include a determination of whether a service, test or procedure is medically necessary and eligible for payment under your plan. In addition, Prior Authorization:

- Utilizes generally accepted standards of good medical practice in the medical community.
- Offers communication between you, your health plan and physician on whether a service will be covered by the plan.

Medical Necessity, *continued*

How does it work?

Within your benefit coverage documents, you will find a list of services that may require Prior Authorization. You or your physician must request that the proposed services be reviewed for coverage. This will allow UnitedHealthcare to review the request and provide a determination of whether the requested service will be covered under your plan.

Generally, when seeking medical services from a network provider — a physician, facility or other health care professional who contracts to participate in the UnitedHealthcare network — your network provider will facilitate this process for you. When seeking services from a non-network provider (if applicable), you will be responsible for obtaining Prior Authorization.

You and your physician will receive a letter by mail once a determination is made. If the service is approved, you and your physician may proceed with the acknowledgment that the service will be covered. Please review your approval letter carefully so that you understand what services have been authorized and where you can obtain those services.

Please note that the decision is based on whether benefits are available under the policy for the proposed treatment or procedure, and thus payable under the policy. Treatment or procedure decisions are between you and your physician.

If a different service is rendered than what was authorized, upon claim receipt the additional services received will be reviewed for coverage under your plan. If you or your physician do not agree with the determination, a reconsideration or appeal can be requested.

Prior Authorization Process

1. Member visits a physician for care and physician recommends a test, procedure or service that requires prior authorization.
2. Physician or facility contacts UnitedHealthcare to inform us of the proposed service.
3. UnitedHealthcare reviews the request to verify the service is a covered benefit and is medically necessary. A determination is rendered.
4. Physician and member review determination letter and plan a course of care.
5. Claim is submitted for service rendered.

Frequently Asked Questions: Medical Necessity/Prior Authorization

How does the prior authorization process work?

If prior authorization is required, a clinical coverage review will be conducted prior to the service being performed to determine whether the service is medically necessary based on evidence-based clinical guidelines. Prior authorization is a process that must be completed before the service is performed.

How can you determine if prior authorization is required for a procedure?

You can call the toll-free member number on your health plan ID card to confirm prior authorization requirements.

How can you confirm if you are responsible for obtaining a prior authorization?

Your benefit coverage documents will summarize the prior authorization requirements. Generally, your network provider—a physician, facility or other health care professional who contracts to participate in the UnitedHealthcare network—will facilitate this process for you. When seeking services from a non-network provider, you will be responsible for obtaining prior authorization. You may call the number on the back of your ID card to confirm your prior authorization requirements, check the status of a determination, or ask questions about your determination letter.

How to request prior authorization.

When you are responsible for obtaining Prior Authorization, you may call the phone number on the back of your health plan ID card. Although your provider may not be required to call, he/she may call, as a courtesy to you, to obtain Prior Authorization on your behalf.

How will you be notified of the outcome of your prior authorization request?

You will receive a determination letter by mail and a copy will be sent to your provider.

Are you responsible for the cost of the service when the service is determined to be not medically necessary?

If it is determined that the service is not medically necessary, the claim for the service will be denied. You can be billed by a network provider for claims that are denied for services that did not meet medical necessity, if the provider obtained adequate written consent from you before performing the service.

How do you appeal a request that did not meet medical necessity?

If the request does not meet medical necessity, the determination letter will include an explanation for the decision, the criteria used and available appeal rights.

Medical and Pharmacy Fertility Benefit for AFSCME 1632 & 2191, CWA, IAFF and HACP/MCP Ordinance Groups

Not everyone follows the same path to building a family.

*And not every journey follows the expectation of 'want a baby, get pregnant, have a baby, return to work'. Physical, emotional, and financial well-being can be impacted when navigating the complexities of trying to build a family. The City of Columbus is offering aspiring and expecting parents access to resources that can support them on their unique path to parenthood for AFSCME 1632 & 2191, CWA, IAFF and HACP/MCP Ordinance Groups.**

Resources available:

- $30,000 lifetime maximum benefit for coverage for Medical and Pharmacy fertility services through your UnitedHealthcare plan.
- Members must enroll in the Fertility Solutions Program *prior to receiving services*, to receive coverage. To enroll in the Fertility Solutions program, call a nurse at 1-866-774-4626.
- Members must use a Center of Excellence for services to be covered. The Fertility Nurse will assist you in finding the COE provider.
- Personalized access to maternity nurses and educational resources before, during and after your pregnancy through Maternity Support Program.

The UnitedHealthcare Medical and Pharmacy plans provide medical and pharmaceutical coverage for fertility services. The medical plan covers fertility treatments such as IUI, IVF, ICSI, and egg retrieval and freezing. Fertility medication is also covered. The combined lifetime maximum benefit for all medical and pharmacy expenses is $30,000 and members must use Centers of Excellence Providers.

*Not available to FOP currently.

Have questions about medical fertility benefits?

Call the number on the back of your UnitedHealthcare ID card, or call the Fertility Solutions team directly at **1-866-774-4626.**

Clinical Programs

Take advantage of these no-cost services.

We're making it easy to see exactly what's included in your UHC benefits. Check out these resources to get the support you need. That way, you can feel confident you're making the right decisions — for you and your family.

Advocate4Me
From medical questions to benefits questions, health care can be confusing. We're here to point you in the right direction.

Cancer Support Services
Cancer Resource Services offers information and member assistance through a team of experienced cancer nurse consultants. They are available to help individuals understand their own or a family member's cancer diagnosis, its implications and possible treatments. They help our members make informed decisions about their care and where to receive care. While most individuals are able to get the care they need close to home, others may benefit from being treated or getting a second opinion in our cancer Centers of Excellence (COE) network.

Asthma Support Program
Get ongoing 1-on-1 support from a nurse, so you can breathe easier. You'll learn how small steps can lead to big changes – and potentially better results.

Diabetes Support Program
Connect 1-on-1 with a registered nurse, who is here to help you create an action plan, track your progress and help you stay motivated to maintain a healthy lifestyle.

Kaia*
Virtual Personalized Therapy. Customized programs to help improve strength and mobility, with real-time exercise feedback and safety guidance from clinically validated motion analysis technology from the comfort of your home.

Condition Management
Managing a chronic condition can be difficult, but you don't have to do it alone. A registered nurse is here to work with you between doctor visits and help you manage your condition.

Maternity Support
If you're thinking about having a baby or have one on the way, a maternity nurse is here to guide you through your pregnancy and after you give birth.

Kidney Resource Services
A specialized nurse can help you manage your condition and explore treatment options. Also take advantage of top-performing centers through our preferred network.

Specialist Management Solutions
Do you live with back, knee, hip, neck or shoulder pain? This program is here to provide personalized support to help you get the care you need.

2nd MD*
The Second Opinion service provides access to convenient, live virtual and phone consultations with medical experts, helping employees make more informed decisions about their care and treatment.

*Not available to FOP currently.

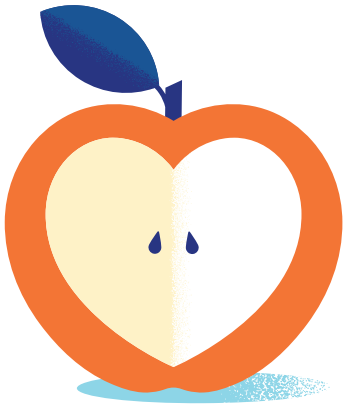
You can easily access these services by calling the number on your health plan ID card.

Your journey to a healthier lifestyle begins here.

Welcome to Rally

Rally® is designed to help you take charge of your health by putting your benefits and resources in one place.

Hitting your goals can be fun with personalized recommendations, as well as missions and challenges that may help make getting healthier more enjoyable. Plus, you can earn rewards along the way.



1. Register and create your Rally profile

If you're a first-time user, create a username that's fun and memorable – but not your real name – and choose an avatar. If you're already a member, simply sign in.

2. Take the health survey

The Health Survey is designed to help you assess your overall health. You may use the results to help set your health goals. (incented)

3. Get personalized recommendations

Based on your Health Survey results, you'll receive personalized recommendations to help you live a healthier lifestyle – including well-being programs, everyday activities called missions and more.

4. Choose healthy activities to hit your goals

Take your pick of a wide variety of missions designed to help improve your fitness, diet and mood. Compete in challenges against friends or other members – or go for a personal best.

5. Get rewarded for getting healthy

Take healthy actions to achieve your goals and earn Rally Points, which are redeemable for a variety of rewards.

6. Dive into communities

Interact with other members in a positive, friendly environment to get tips, motivation, and support on everything from diet and fitness to sleep, back pain and even relationships.

Visit **myuhc.com®** for more information on Rally.

Stressed? Anxious? With virtual therapy, getting help may now be easier than ever.

Reaching out may be hard —especially if you might not want anyone to know you're hurting. From the privacy of home and the convenience of your mobile device or computer, you can receive caring support from a licensed behavioral health virtual therapist.*

Virtual therapy offers confidential counseling and includes:

Private video sessions.
Get 1-on-1 support – in your home and at a time that's convenient for you.

Help with coping – for children, teens and adults.
Your licensed virtual therapist may provide a diagnosis, treatment and medication if needed.

Similar standard of care as in-person visits.
You can see the same therapist with each appointment and establish an ongoing relationship.

Virtual therapy is designed to help treat conditions like:

- ADD/ADHD
- Addiction
- Anxiety
- Depression
- Mental health disorders

A quicker way for the whole family to get care.

Virtual therapy may be a great way for children and teens to get an appointment.

To find a provider and schedule a visit:

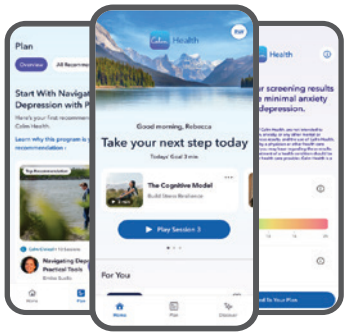
1. Sign in or register on **myuhc.com®**.
   Then, go to ***Find Care*** › ***Virtual Visits Directory*** › ***Virtual Behavioral Care*** › ***Get Started.***
2. Call the provider to set up an appointment.

*Data rates may apply.

Behavioral Health Benefits

Make the mind/body connection with Calm Health

The Calm Health app provides programs and tools to help support your mental health and well-being — all at your own pace. As a UnitedHealthcare member, Calm Health is included in your health plan and available at no additional cost.



Resources to help support your mental health

To help tailor your Calm Health experience, you'll begin with a short mental health screening. Then, Calm Health will suggest certain programs for you to consider based on where you are in your well-being journey.

Tap into tools and support

The Calm Health app brings you a library of support — including mindfulness content and programs created by psychologists — for a variety of health experiences and life stages. This information is designed to help you:

- **Learn techniques to improve well-being** – Find tools, music and sounds to help you meditate, improve focus, move mindfully and feel calm
- **Work toward goals** – Join self-guided self-care programs, and track your progress along the way
- **Support your mind and body** – Access mental health information and support to help you strengthen the mind-body connection

Scan this code to get started

You'll first need to sign in to your account on myuhc.com® or the UnitedHealthcare® app.

If you don't have an account, select Register to create one.

Behavioral Health Benefits

Message a dedicated therapist any time, anywhere with Talkspace

Something on your mind?

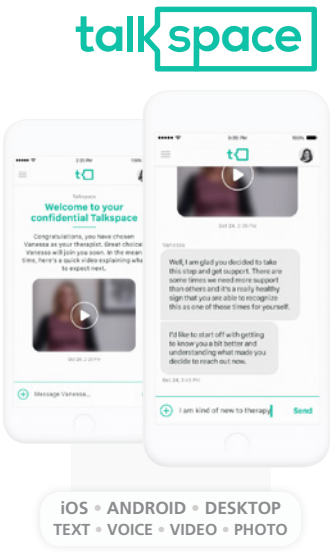
With Talkspace online therapy, you can regularly communicate with a therapist, safely and securely from your smartphone or computer.

Make progress. No office visit required.

Here's how Talkspace can fit your life:

- With Talkspace, you can message a licensed therapist, 24/7.
- Find a therapist with an online matching tool.
- Start therapy within hours of choosing your therapist.
- Therapists respond daily, five days a week.
- Schedule live video sessions, when needed.
- Download the Talkspace app on your smartphone or computer.

Talkspace is your space. To use in your time. It's private, confidential and convenient. And it's covered under your Optum behavioral health benefits.*



Talkspace is convenient, safe and secure.

Simply register (first visit only) and choose a provider at **www.talkspace.com/connect.** Then message any time, anywhere.

* Copayment may apply and will be charged weekly via credit card. You may use Talkspace as often as desired per week once copayment for that week has been paid.

2025 Dental Benefits: FOP

Covered Services

	Delta Dental PPO Dentist Plan Pays	Delta Dental Premier Dentist Plan Pays	Nonparticipating Dentist Plan Pays*
Diagnostic & Preventive			
Diagnostic and Preventive Services – exams, cleanings and fluoride	100%	100%	100%
Emergency Palliative Treatment – to temporarily relieve pain	100%	100%	100%
Brush Biopsy – to detect oral cancer	100%	100%	100%
Radiographs – X-rays	100%	100%	100%
Basic Services			
Sealants – to prevent decay of permanent teeth	75%	75%	75%
Minor Restorative Services – fillings and crown repair	75%	75%	75%
Endodontic Services – root canals	75%	75%	75%
Periodontic Services – to treat gum disease	75%	75%	75%
Oral Surgery Services – extractions and dental surgery	75%	75%	75%
Other Basic Services – misc. services	75%	75%	75%
Relines and Repairs – to bridges, implants, and dentures	75%	75%	75%
Major Services			
Prosthodontic Services – bridges, dentures, and crowns over implants	75%	75%	75%
Implants – endosteal implants to replace missing teeth	50%	50%	50%
Orthodontic Services			
Orthodontic Services – braces	75%	75%	75%
Orthodontic Age Limit – *PPO, Premier and Non-Participating combined*	treatment must begin prior to age 19 and coverage will continue to the end of treatment or until the maximum has been reached		
Maximum Payment per Benefit Year – (Does not include orthodontics) *PPO, Premier and Non-Participating combined*	$1,500		
Orthodontics per Lifetime *PPO, Premier and Non-Participating combined*	$2,500		

Frequency

Oral Exams (including evaluations by a specialist)	Twice in any 12 consecutive month period
Prophylaxes (cleanings)	Twice in any 12 consecutive month period – Benefits for periodontal maintenance procedures are unlimited
Fluoride Treatments – No age limit	Twice in any 12 consecutive month period
Space Maintainers – Age 18 and under	Once per area per lifetime
Bitewing Xrays	Twice in any 12 consecutive month period
Full Mouth Xrays including Bitewings	Once in any 3 year period
Crowns over Implants	Once per tooth in any 5 year period
Sealants – Age 18 and under	First and second permanent molars and bicuspids which are free from decay and restorations

* When you receive services from a Nonparticipating Dentist, the percentages in this column indicate the portion of Delta Dental's Nonparticipating Dentist Fee that will be paid for those services. This amount may be less than what the Dentist charges or Delta Dental approves and you are responsible for that difference.

2025 Dental Benefits: IAFF

Covered Services

	Delta Dental PPO Dentist Plan Pays	Delta Dental Premier Dentist Plan Pays	Nonparticipating Dentist Plan Pays*
Diagnostic & Preventive			
Diagnostic and Preventive Services – exams, cleanings and fluoride	100%	100%	100%
Emergency Palliative Treatment – to temporarily relieve pain	100%	100%	100%
Brush Biopsy – to detect oral cancer	100%	100%	100%
Radiographs – X-rays	100%	100%	100%
Basic Services			
Sealants – to prevent decay of permanent teeth	75%	75%	75%
Minor Restorative Services – fillings and crown repair	75%	75%	75%
Endodontic Services – root canals	75%	75%	75%
Periodontic Services – to treat gum disease	75%	75%	75%
Oral Surgery Services – extractions and dental surgery	75%	75%	75%
Other Basic Services – misc. services	75%	75%	75%
Relines and Repairs – to bridges, implants, and dentures	75%	75%	75%
Major Services			
Prosthodontic Services – bridges, dentures, and crowns over implants	75%	75%	75%
Implants – endosteal implants to replace missing teeth	50%	50%	50%
Orthodontic Services			
Orthodontic Services – braces	75%	75%	75%
Orthodontic Age Limit – *PPO, Premier and Non-Participating combined*	treatment must begin prior to age 19 and coverage will continue to the end of treatment or until the maximum has been reached		
Maximum Payment per Benefit Year – (Does not include orthodontics) *PPO, Premier and Non-Participating combined*	$1,500		
Orthodontics per Lifetime *PPO, Premier and Non-Participating combined*	$1,850		

Frequency

Oral Exams (including evaluations by a specialist)	Twice in any 12 consecutive month period
Prophylaxes (cleanings)	Twice in any 12 consecutive month period – Benefits for periodontal maintenance procedures are unlimited
Fluoride Treatments – No age limit	Twice in any 12 consecutive month period
Space Maintainers – Age 18 and under	Once per area per lifetime
Bitewing Xrays	Twice in any 12 consecutive month period
Full Mouth Xrays including Bitewings	Once in any 3 year period
Crowns over Implants	Once per tooth in any 5 year period
Sealants – Age 18 and under	First and second permanent molars and bicuspids which are free from decay and restorations

* When you receive services from a Nonparticipating Dentist, the percentages in this column indicate the portion of Delta Dental's Nonparticipating Dentist Fee that will be paid for those services. This amount may be less than what the Dentist charges or Delta Dental approves and you are responsible for that difference.

2025 Dental Benefits: AFSCME 1632 & 2191 and CWA

Covered Services

	Delta Dental PPO Dentist Plan Pays	Delta Dental Premier Dentist Plan Pays	Nonparticipating Dentist Plan Pays*
Diagnostic & Preventive			
Diagnostic and Preventive Services – exams, cleanings and fluoride	100%	100%	100%
Brush Biopsy – to detect oral cancer	100%	100%	100%
Basic Services			
Space Maintainers – appliances to prevent tooth movement, space maintainers	75%	75%	75%
Emergency Palliative Treatment – to temporarily relieve pain	75%	75%	75%
Sealants – to prevent decay of permanent teeth	75%	75%	75%
Radiographs – X-rays	75%	75%	75%
Minor Restorative Services – fillings and crown repair	75%	75%	75%
Endodontic Services – root canals	75%	75%	75%
Periodontic Services – to treat gum disease	75%	75%	75%
Oral Surgery Services – extractions and dental surgery	75%	75%	75%
Other Basic Services – misc. services	75%	75%	75%
Relines and Repairs – to bridges, implants, and dentures	75%	75%	75%
Major Services			
Major Restorative Services – crowns	50%	50%	50%
Prosthodontic Services – bridges, implants and dentures	50%	50%	50%
Orthodontic Services			
Orthodontic Services – braces	50%	50%	50%
Orthodontic Age Limit *PPO, Premier and Non-Participating combined*	treatment must begin prior to age 19 and coverage will continue to the end of treatment or until the maximum has been reached		
Maximum Payment per Benefit Year – (Does not include orthodontics) *PPO, Premier and Non-Participating combined*	$1,500		
Orthodontics per Lifetime *PPO, Premier and Non-Participating combined*	$1,850		

Frequency

Oral Exams (including evaluations by a specialist)	Twice in any 12 consecutive month period
Prophylaxes (cleanings)	Twice in any 12 consecutive month period – Benefits for periodontal maintenance procedures are unlimited
Fluoride Treatments – No age limit	Twice in any 12 consecutive month period
Space Maintainers – Age 18 and under	Once per area per lifetime
Bitewing Xrays	Twice in any 12 consecutive month period
Full Mouth Xrays including Bitewings	Once in any 3 year period
Crowns over Implants	Once per tooth in any 5 year period
Sealants – Age 18 and under	First and second permanent molars and bicuspids which are free from decay and restorations

* When you receive services from a Nonparticipating Dentist, the percentages in this column indicate the portion of Delta Dental's Nonparticipating Dentist Fee that will be paid for those services. This amount may be less than what the Dentist charges or Delta Dental approves and you are responsible for that difference.

2025 Dental Benefits: OLC and HACP/MCP Ordinance Groups

Covered Services

	Delta Dental PPO Dentist Plan Pays	Delta Dental Premier Dentist Plan Pays	Nonparticipating Dentist Plan Pays*
Diagnostic & Preventive			
Diagnostic and Preventive Services – exams, cleanings and fluoride	100%	100%	100%
Palliative Treatment – to temporarily relieve pain	100%	100%	100%
Brush Biopsy – to detect oral cancer	100%	100%	100%
Basic Services			
Space Maintainers - appliances to prevent tooth movement	80%	70%	70%
Sealants – to prevent decay of permanent teeth	80%	70%	70%
Radiographs - X-rays	80%	70%	70%
Minor Restorative Services – fillings and crown repair	80%	70%	70%
Endodontic Services – root canals	80%	70%	70%
Periodontic Services – to treat gum disease	80%	70%	70%
Oral Surgery Services – extractions and dental surgery	80%	70%	70%
Other Basic Services – misc. services	80%	70%	70%
Relines and Repairs – to prosthetic devices	80%	70%	70%
Major Services			
Major Restorative Services – crowns	60%	50%	50%
Prosthodontic Services – bridges, dentures, and crowns over implants	60%	50%	50%
Orthodontic Services			
Orthodontic Services – braces	50%	50%	50%
Orthodontic Age Limit	This lifetime maximum payable for any covered members		
Maximum Payment per Benefit Year – (Does not include diagnostic, prophylaxes (cleanings), emergency palliative, fluoride, and brush biopsy) *PPO, Premier and Non-Participating combined*	$1,500		
Orthodontics per Lifetime *PPO, Premier and Non-Participating combined*	$1,850		

Frequency

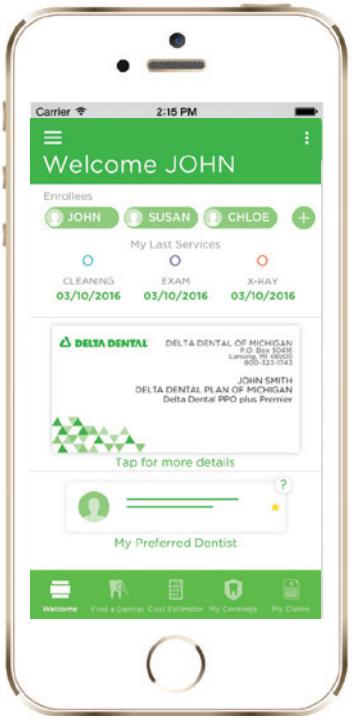
Oral Exams (including evaluations by a specialist)	Twice per calendar year
Prophylaxes (cleanings)	Twice per calendar year – Benefits for periodontal maintenance procedures are unlimited
Fluoride Treatments – No age limit	Twice per calendar year
Space Maintainers – Age 18 and under	Once per area per lifetime
Bitewing X-rays	Twice in any 12 consecutive month period
Full Mouth X-rays including Bitewings	Once in any 3 year period
Crowns over Implants	Once per tooth in any 5 year period
Sealants – Age 18 and under	First and second permanent molars and bicuspids which are free from decay and restorations

* When you receive services from a Nonparticipating Dentist, the percentages in this column indicate the portion of Delta Dental's Nonparticipating Dentist Fee that will be paid for those services. This amount may be less than what the Dentist charges or Delta Dental approves and you are responsible for that difference.

Delta Dental

Your dental benefits, at your fingertips!

The Delta Dental Mobile App helps you get the most out of your dental benefits anytime, anywhere. Use the dentist search or toothbrush timer without logging in, or enter your username and password to securely access your personal benefit information or estimate your dental care costs.



» Coverage and claims information

See your plan type, benefit levels, deductibles, maximums and more. Check the status of recent dental claims. Add your dependents to your account to be able to access the whole family's coverage in one spot.

» Dental Care Cost Estimator

This easy-to-use tool provides estimated cost ranges on common dental care needs for dentists in your area. You can even select your dentist for tailored cost estimates.

» Dentist search

It's easy to find a participating dentist near you! Search and compare dental offices to find one that suits your needs. Narrow the list with criteria like 'language spoken' and 'specialty.' After you choose a dentist, you can save the contact information and get directions.

» Mobile ID card

There's no longer a need to carry a paper ID card. Simply show the dentist's office your mobile ID card right on your screen. Easily save it to your device for quick access using Apple Passbook or Google Wallet.

» Toothbrush timer

Keep up with your oral health routine by using this handy tool. Our timer counts down for two minutes while reminding you to brush each tooth.

Get started

Delta Dental's free app is optimized for iOS (Apple) and Android devices. To download our app on your device, visit the App Store (Apple) or Google Play (Android) and search for **Delta Dental**.

Log in for secure access

Delta Dental subscribers can log in using the username and password used to log in to www.deltadentaloh.com. If you haven't registered for an account yet, you can do so within the app. If you've forgotten your username or password, you can also retrieve these within the app. You must log in each time you access the secure portion of the app. No personal health information is ever stored on your device.

Current IAFF and FOP Vision Coverage Summary: EyeMed

40% OFF additional complete pair of prescription eyeglasses

20% OFF non-covered items, including non-prescription sunglasses

Find an Eye Doctor
(Insight Network)

- eyemed.com
- EyeMed Members App
- For LASIK, call 1-800-988-4221

Heads Up
You may have additional benefits. Log into **eyemed.com/member** to see all plans included with your benefits.

Vision Care Services	In-Network Member Cost	Out-Of-Network Member Reimbursement
EXAM SERVICES		
Exam	$0 copay	Up to $35
Retinal Imaging	Up to $39	Not covered
CONTACT LENS FIT AND FOLLOW-UP		
Fit & Follow-up - Standard	Up to $40; contact lens fit and two follow-up visits	Not covered
Fit & Follow-up - Premium	10% off retail price	Not covered
FRAME		
Frame	$0 copay; 20% off balance over $150 allowance	Up to $35
STANDARD PLASTIC LENSES		
Single Vision	$0 copay	Up to $35
Bifocal	$0 copay	Up to $50
Trifocal	$0 copay	Up to $60
Lenticular	$0 copay	Up to $90
Progressive - Standard	$55 copay	Up to $50
Progressive - Premium Tier 1-4	$85 - 175 copay	Up to $50
LENS OPTIONS		
Anti Reflective Coating - Standard	$45 copay	Up to $5
Anti Reflective Coating - Premium Tier 1 - 3	$57 - 85 copay	Up to $5
Photochromic - Non-Glass	$75	Not covered
Polycarbonate - Standard	$0 copay	Up to $5
Scratch Coating - Standard Plastic	$15	Not covered
Tint - Solid and Gradient	$15	Not covered
UV Treatment	$15	Not covered
All Other Lens Options	20% off retail price	Not covered
CONTACT LENSES		
Contacts - Conventional	$0 copay; 15% off balance over $150 allowance	Up to $90
Contacts - Disposable	$0 copay; 100% of balance over $150 allowance	Up to $90
Contacts - Medically Necessary	$0 copay; paid-in-full	Up to $210
OTHER		
Hearing Care from Amplifon Network	Discounts on hearing exam and aids; call 1.877.203.0675	Not covered
Lasik or PRK from U.S. Laser Network	15% off retail or 5% off promo price; call 1.800.988.4221	Not covered

FREQUENCY	ALLOWED FREQUENCY – ADULTS	ALLOWED FREQUENCY – KIDS
Exam	Once every plan year	Once every plan year
Frame	Once every other plan year	Once every other plan year
Lenses	Once every plan year	Once every plan year
Contacts Lenses	Once every plan year	Once every plan year

(Plan allows member to receive either contacts and frame, or frame and lens services)

Current AFSCME 1632 & 2191, CWA, OLC and HACP/MCP Ordinance Groups Vision Coverage Summary: EyeMed

40% OFF additional complete pair of prescription eyeglasses

20% OFF non-covered items, including non-prescription sunglasses

Find an Eye Doctor
(Insight Network)

- eyemed.com
- EyeMed Members App
- For LASIK, call 1-800-988-4221

Heads Up
You may have additional benefits. Log into **eyemed.com/member** to see all plans included with your benefits.

Vision Care Services	In-Network Member Cost	Out-Of-Network Member Reimbursement
EXAM SERVICES		
Exam	$5 copay	Up to $35
Retinal Imaging	Up to $39	Not covered
CONTACT LENS FIT AND FOLLOW-UP		
Fit & Follow-up - Standard	Up to $40; contact lens fit and two follow-up visits	Not covered
Fit & Follow-up - Premium	10% off retail price	Not covered
FRAME		
Frame	$0 copay; 20% off balance over $150 allowance	Up to $35
STANDARD PLASTIC LENSES		
Single Vision	$12.50 copay	Up to $35
Bifocal	$12.50 copay	Up to $50
Trifocal	$12.50 copay	Up to $60
Lenticular	$12.50 copay	Up to $90
Progressive - Standard	$55 copay	Up to $50
Progressive - Premium Tier 1 - 4	$85 - 175 copay	Up to $50
LENS OPTIONS		
Anti Reflective Coating - Standard	$45 copay	Up to $5
Anti Reflective Coating - Premium Tier 1 - 3	$57 - 85 copay	Up to $5
Photochromic - Non-Glass	$75	Not covered
Polycarbonate - Standard	$0 copay	Up to $5
Scratch Coating - Standard Plastic	$15	Not covered
Tint - Solid and Gradient	$15	Not covered
UV Treatment	$15	Not covered
All Other Lens Options	20% off retail price	Not covered
CONTACT LENSES		
Contacts - Conventional	$0 copay; 15% off balance over $150 allowance	Up to $90
Contacts - Disposable	$0 copay; 100% of balance over $150 allowance	Up to $90
Contacts - Medically Necessary	$0 copay; paid-in-full	Up to $210
OTHER		
Hearing Care from Amplifon Network	Discounts on hearing exam and aids; call 1-877-203-0675	Not covered
Lasik or PRK from U.S. Laser Network	15% off retail or 5% off promo price; call 1-800-988-4221	Not covered

FREQUENCY	ALLOWED FREQUENCY – ADULTS	ALLOWED FREQUENCY – KIDS
Exam	Once every plan year	Once every plan year
Frame	Once every other plan year	Once every other plan year
Lenses	Once every plan year	Once every plan year
Contacts Lenses	Once every plan year	Once every plan year

(Plan allows member to receive either contacts and frame, or frame and lens services)

City of Columbus
EyeMed Vision Care Diabetic Product

Diabetic Care Services	In-Network Member Cost	Out-Of-Network Member Reimbursement
For Type 1 or Type 2 Diabetes with Diabetic Retinopathy		
Medical Follow Up Eye Examination	$0 copay	Up to $77
Fundus Photography Examination	$0 copay	Up to $50
Extended Ophthalmoscopy (initial and subsequent)	$0 copay	Up to $15
Gonioscopy	$0 copay	Up to $15
Scanning Laser	$0 copay	Up to $33

Vision Care Definitions

Medical Follow-Up Examination means an office visit for diabetic vision care after the initial Comprehensive Eye Examination.

Some or all of the diagnostic services described below will be provided as deemed appropriate, subject to provider determination and the benefit frequency limitations referenced above. More comprehensive descriptions of these services are available in the Certificate of Insurance.

Fundus Photography Examination means photographing portion(s) of or the complete retina surface and structures, with interpretation and report. (*The Fundus Photography Examination is not covered if an Extended Ophthalmoscopy was provided within the previous six-month period.)

Extended Ophthalmoscopy means an examination of the interior of the eye, focusing on the posterior segment of the eye, including the lens, retina, and optic nerve, by direct or indirect ophthalmoscopy, and includes a retinal drawing with interpretation and report. (*The Extended Ophthalmoscopy is not covered if Fundus Photography Examination was provided within the previous six-month period)

Gonioscopy means an eye examination of the front part of the eye (anterior chamber) to check the angle where the iris meets the cornea with a gonioscope or with a contact prism lens.

Scanning Laser means a computerized ophthalmic diagnostic imaging, posterior segment, with interpretation and report.

Basic Group Term Life Insurance Benefit Highlights: IAFF

CITY OF COLUMBUS, IAFF

The group term life insurance available through your employer gives extra protection that you and your family may need. Life insurance offers financial protection by providing you coverage in case of an untimely death. Life insurance is disbursed to your beneficiaries in a lump sum in the event of your death.

To learn more about Life insurance, visit **thehartford.com/employeebenefits**

COVERAGE INFORMATION	**Applicant** Employee	**Life Coverage** Benefit: $100,000

ASKED & ANSWERED

Who is eligible?

You are eligible if you are an active full time City of Columbus IAFF employee who works at least 30 hours per week on a regularly scheduled basis, excluding IAFF Fire Battalion Chiefs and Deputy Fire Chiefs.

Am I guaranteed coverage?

This insurance is guaranteed issue coverage - it is available without having to provide information about your health.

When can I enroll?

Your enrollment is completed online through the employee self-service Dayforce system. Enrollment must be completed within the first 30 days of eligibility. If you have not already done so, you must designate a beneficiary.

When does this insurance begin?

This insurance will become effective for you on the 1st of the month coinciding with or following your full time hire date. You must be actively at work with your employer on the day your coverage takes effect.

When does this insurance end?

This insurance will end when you no longer satisfy the applicable eligibility conditions, premium is unpaid, you are no longer actively working, you leave your employer, or the coverage is no longer offered.

Can I keep this insurance if I leave my employer or am no longer a member of this group?

Yes, you can take this life coverage with you. Coverage may be continued for you under a group portability certificate or an individual conversion life certificate. The specific terms and qualifying events for conversion and portability are described in the certificate.

LIMITATIONS & EXCLUSIONS

This insurance coverage includes certain limitations and exclusions. The certificate details all provisions, limitations, and exclusions for this insurance coverage. A copy of the certificate can be obtained from your employer.

GROUP LIFE INSURANCE
General Limitations and Exclusions

- You must be a citizen or legal resident of the United States, its territories and protectorates.

Basic Group Term Life Insurance Benefit Highlights:
AFSCME 1632, AFSCME 2191, MCP or HACP

CITY OF COLUMBUS, AFSCME 1632, AFSCME 2191, MCP, HACP

The group term life insurance available through your employer gives extra protection that you and your family may need. Life insurance offers financial protection by providing you coverage in case of an untimely death. Life insurance is disbursed to your beneficiaries in a lump sum in the event of your death.

To learn more about Life insurance, visit **thehartford.com/employeebenefits**

COVERAGE INFORMATION	**Applicant** Employee	**Life Coverage** Benefit: 1.5 times annual salary Maximum: $200,000

ASKED & ANSWERED

Who is eligible?
You are eligible if you are an active full time City of Columbus AFSCME 1632, AFSCME 2191, MCP or HACP employee who works at least 30 hours per week on a regularly scheduled basis.

Am I guaranteed coverage?
This insurance is guaranteed issue coverage - it is available without having to provide information about your health.

When can I enroll?
Your enrollment is completed online through the employee self-service Dayforce system. Enrollment must be completed within the first 30 days of eligibility. If you have not already done so, you must designate a beneficiary.

When does this insurance begin?
This insurance will become effective on the 1st of the month following your full time hire date. You must be actively at work with your employer on the day your coverage takes effect.

When does this insurance end?
This insurance will end when you no longer satisfy the applicable eligibility conditions, premium is unpaid, you are no longer actively working, you leave your employer, or the coverage is no longer offered.

Can I keep this insurance if I leave my employer or am no longer a member of this group?
Yes, you can take this life coverage with you. Coverage may be continued for you under a group portability certificate or an individual conversion life certificate. The specific terms and qualifying events for conversion and portability are described in the certificate.

LIMITATIONS & EXCLUSIONS

This insurance coverage includes certain limitations and exclusions. The certificate details all provisions, limitations, and exclusions for this insurance coverage. A copy of the certificate can be obtained from your employer.

GROUP LIFE INSURANCE
General Limitations and Exclusions

- Your benefit will be reduced to 65% at age 65 (not to exceed $65,000) and to 39% at age 70 (not to exceed $39,000). Reductions will be applied to the original coverage amount.
- You must be a citizen or legal resident of the United States, its territories and protectorates.

Basic Group Term Life Insurance Benefit Highlights: FOP-MCP, FIRE MCP – Fire Chief, Fire Assistant Chief, Battalion Chiefs or Deputy Chief

CITY OF COLUMBUS, FOP-MCP, FIRE MCP – FIRE CHIEF, FIRE ASSISTANT CHIEF, BATTALION CHIEFS, OR DEPUTY CHIEF

The group term life insurance available through your employer gives extra protection that you and your family may need. Life insurance offers financial protection by providing you coverage in case of an untimely death. Life insurance is disbursed to your beneficiaries in a lump sum in the event of your death.

To learn more about Life insurance, visit **thehartford.com/employeebenefits**

COVERAGE INFORMATION	**Applicant** Employee	**Life Coverage** Benefit: 1x annual salary, to a maximum of $200,000

ASKED & ANSWERED

Who is eligible?

You are eligible if you are an active full time City of Columbus FOP-MCP, FIRE MCP – Fire Chief, Fire Assistant Chief, Battalion Chief, or Deputy Chief who works at least 30 hours per week on a regularly scheduled basis.

Am I guaranteed coverage?

This insurance is guaranteed issue coverage - it is available without having to provide information about your health.

When can I enroll?

Your enrollment is completed online through the employee self-service Dayforce system. Enrollment must be completed within the first 30 days of eligibility. If you have not already done so, you must designate a beneficiary.

When does this insurance begin?

This insurance will become effective for you on the 1st of the month following your full time hire date. You must be actively at work with your employer on the day your coverage takes effect.

When does this insurance end?

This insurance will end when you no longer satisfy the applicable eligibility conditions, premium is unpaid, you are no longer actively working, you leave your employer, or the coverage is no longer offered.

Can I keep this insurance if I leave my employer or am no longer a member of this group?

Yes, you can take this life coverage with you. Coverage may be continued for you under a group portability certificate or an individual conversion life certificate. The specific terms and qualifying events for conversion and portability are described in the certificate.

LIMITATIONS & EXCLUSIONS

This insurance coverage includes certain limitations and exclusions. The certificate details all provisions, limitations, and exclusions for this insurance coverage. A copy of the certificate can be obtained from your employer.

GROUP LIFE INSURANCE

General Limitations and Exclusions

• You must be a citizen or legal resident of the United States, its territories and protectorates.

Basic Group Term Life Insurance Benefit Highlights: FOP-OLC

CITY OF COLUMBUS, FOP-OLC

The group term life insurance available through your employer gives extra protection that you and your family may need. Life insurance offers financial protection by providing you coverage in case of an untimely death. Life insurance is disbursed to your beneficiaries in a lump sum in the event of your death.

To learn more about Life insurance, visit **thehartford.com/employeebenefits**

COVERAGE INFORMATION	**Applicant** Employee	**Life Coverage** 1.5 times earnings Maximum: $200,000

ASKED & ANSWERED

Who is eligible?

You are eligible if you are an active full time City of Columbus FOP-OLC employee who works at least 30 hours per week on a regularly scheduled basis.

Am I guaranteed coverage?

This insurance is guaranteed issue coverage - it is available without having to provide information about your health.

When can I enroll?

Your enrollment is completed online through the employee self-service Dayforce system. Enrollment must be completed within the first 30 days of eligibility. If you have not already done so, you must designate a beneficiary.

When does this insurance begin?

This insurance will become effective on the 1st of the month following your full time hire date. You must be actively at work with your employer on the day your coverage takes effect.

When does this insurance end?

This insurance will end when you no longer satisfy the applicable eligibility conditions, premium is unpaid, you are no longer actively working, you leave your employer, or the coverage is no longer offered.

Can I keep this insurance if I leave my employer or am no longer a member of this group?

Yes, you can take this life coverage with you. Coverage may be continued for you under a group portability certificate or an individual conversion life certificate. The specific terms and qualifying events for conversion and portability are described in the certificate.

LIMITATIONS & EXCLUSIONS

This insurance coverage includes certain limitations and exclusions. The certificate details all provisions, limitations, and exclusions for this insurance coverage. A copy of the certificate can be obtained from your employer.

GROUP LIFE INSURANCE

General Limitations and Exclusions

- You must be a citizen or legal resident of the United States, its territories and protectorates.

Basic Group Term Life Insurance Benefit Highlights: FOP

CITY OF COLUMBUS, FOP

The group term life insurance available through your employer gives extra protection that you and your family may need. Life insurance offers financial protection by providing you coverage in case of an untimely death. Life insurance is disbursed to your beneficiaries in a lump sum in the event of your death.

To learn more about Life insurance, visit **thehartford.com/employeebenefits**

COVERAGE INFORMATION	**Applicant** Employee	**Life Coverage** Benefit: $200,000

ASKED & ANSWERED

Who is eligible?

You are eligible if you are an active full time employee subject to a collective bargaining agreement with FOP who works at least 30 hours per week on a regularly scheduled basis.

Am I guaranteed coverage?

This insurance is guaranteed issue coverage - it is available without having to provide information about your health.

When can I enroll?

Your employer will automatically enroll you for this coverage. If you have not already done so, you must designate a beneficiary.

When does this insurance begin?

This insurance will become effective for you on the date you become eligible. You must be actively at work with your employer on the day your coverage takes effect.

When does this insurance end?

This insurance will end when you no longer satisfy the applicable eligibility conditions, premium is unpaid, you are no longer actively working, you leave your employer, or the coverage is no longer offered.

Can I keep this insurance if I leave my employer or am no longer a member of this group?

Yes, you can take this life coverage with you. Coverage may be continued for you under a group portability certificate or an individual conversion life certificate. The specific terms and qualifying events for conversion and portability are described in the certificate.

LIMITATIONS & EXCLUSIONS

This insurance coverage includes certain limitations and exclusions. The certificate details all provisions, limitations, and exclusions for this insurance coverage. A copy of the certificate can be obtained from your employer.

GROUP LIFE INSURANCE

General Limitations and Exclusions

• You must be a citizen or legal resident of the United States, its territories and protectorates.

Basic Group Term Life Insurance Benefit Highlights: CWA

CITY OF COLUMBUS, CWA

The group term life insurance available through your employer gives extra protection that you and your family may need. Life insurance offers financial protection by providing you coverage in case of an untimely death. Life insurance is disbursed to your beneficiaries in a lump sum in the event of your death.

To learn more about Life insurance, visit **thehartford.com/employeebenefits**

COVERAGE INFORMATION	**Applicant** Employee	**Life Coverage** Benefit: 1.5 times earnings Maximum: $250,000

ASKED & ANSWERED

Who is eligible?

You are eligible if you are an active full time employee subject to a collective bargaining agreement with CWA who works at least 30 hours per week on a regularly scheduled basis.

Am I guaranteed coverage?

This insurance is guaranteed issue coverage - it is available without having to provide information about your health.

When can I enroll?

Your employer will automatically enroll you for this coverage. If you have not already done so, you must designate a beneficiary.

When does this insurance begin?

This insurance will become effective for you on the date you become eligible. You must be actively at work with your employer on the day your coverage takes effect.

When does this insurance end?

This insurance will end when you no longer satisfy the applicable eligibility conditions, premium is unpaid, you are no longer actively working, you leave your employer, or the coverage is no longer offered.

Can I keep this insurance if I leave my employer or am no longer a member of this group?

Yes, you can take this life coverage with you. Coverage may be continued for you under a group portability certificate or an individual conversion life certificate. The specific terms and qualifying events for conversion and portability are described in the certificate.

LIMITATIONS & EXCLUSIONS

This insurance coverage includes certain limitations and exclusions. The certificate details all provisions, limitations, and exclusions for this insurance coverage. A copy of the certificate can be obtained from your employer.

GROUP LIFE INSURANCE
General Limitations and Exclusions

• You must be a citizen or legal resident of the United States, its territories and protectorates.

Life Insurance Information 2025: The Hartford

Life insurance from the Hartford can help protect the financial future of your loved ones. And your coverage includes valuable services that can help you and your family.

Funeral Concierge

Helps provide peace of mind when it's needed most.

The Hartford's Funeral Concierge offers a suite of online tools to help guide you through key decisions. It allows for pre-planning, documentation of wishes, and even offers cost comparisons of funeral-related expenses. After a loss, this service includes family advocacy and professional negotiation of funeral prices with local providers – often resulting in significant savings. And Express Pay guarantees beneficiaries can receive payment in as little as 48 hours.

Find out more by calling: **866-854-5429**

Visit: **www.everestfuneral.com/Hartford**

Use code: **HFEVLC**

Beneficiary Assist® Counseling

Getting through a loss is hard. Getting support shouldn't be.

The Hartford offers Beneficiary Assist counseling services, compassionate professionals that can help you or your beneficiaries cope with emotional, financial and legal issues that can arise after a loss. Includes unlimited 24/7 phone access for legal advice, financial planning and emotional counseling, and up to five face-to-face sessions or equivalent professional time for one or a combination of services for up to a year from the date a claim is filed.

Learn more: **800-411-7239**

Life Insurance Information 2025: The Hartford, *continued*

Estate Guidance® Will Services

Create a simple will from the convenience of your home.

Whether your assets are few or many, it's important to have a will. Through the Hartford, you have access to Estate Guidance® Will Services. It helps you protect your family's future by creating a will online – backed by online support from licensed attorneys. Just follow the instructions to create a will that's customized and legally binding.

Visit: **www.estateguidance.com**

Use code: **WILLHLF**

Travel Assistance with ID Theft Protection

Even the best planned trips can be full of surprises.

Travel assistance with ID theft protection includes pre-trip information to help you feel more secure while traveling. It can also help you access professionals across the globe for medical assistance when traveling 100+ miles away from home for 90 days or less. ID theft services are available to you and your family at home or when you travel.

In case of a serious medical emergency when traveling, obtain emergency medical services first (contact the local "911"). Then, contact travel assist to alert them to your situation.

Call: **800-243-6108**

Collect from other locations: **202-828-5885**

Fax: **202-331-1528**

Just provide your employers name, a phone number where you can be reached, nature of the problem, travel assistance identification number **GLD-09012**, and your company policy number **GL-681893**.

Travel Assistance

Call toll end free: **800-243-6108**.

Collect from other locations: **202-828-5885.**

Fax: **202-331-1528**.

What to have ready:

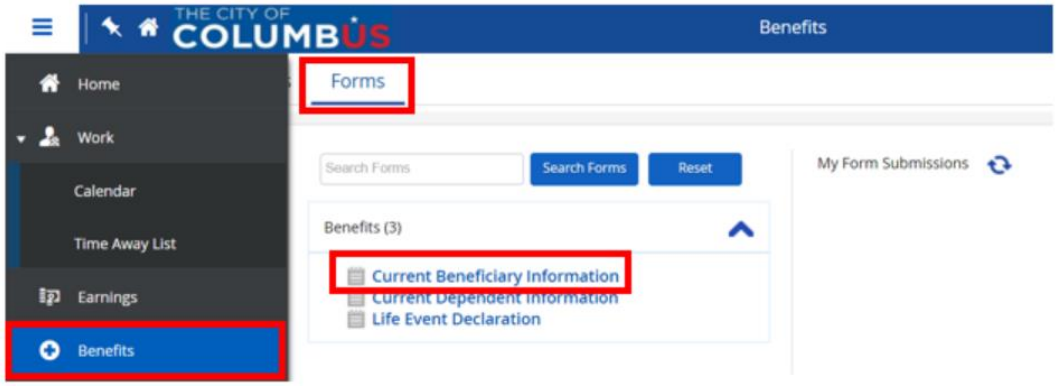
- Your employers name.
- Your phone number. Nature of the problem.
- Your employers group policy number: **GL-681893**
- Your travel assist ID number: **GLD-09012**

TheHartford.com/employeebenefits

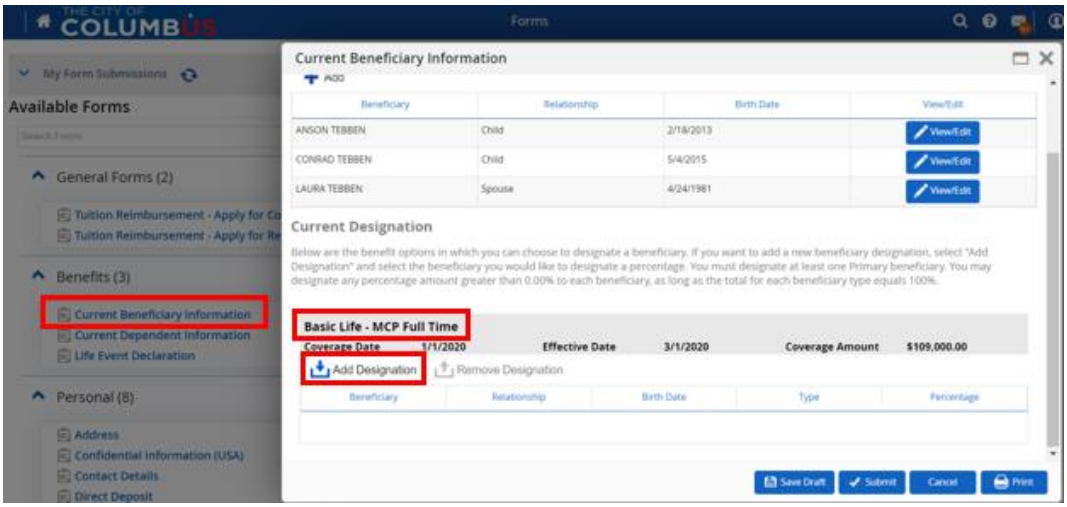
Updating Your Beneficiary Designation in Dayforce

Employees who have life insurance are required to list their beneficiaries in Dayforce as this information was available only in hardcopy previously. Adding beneficiaries is simple. Here is how:

STEP 1. Click on Forms from the Benefits menu in your Employee Self Service (ESS) role.



STEP 2. Click on Current Beneficiary Information. Add Designation under Basic Life on the form to add the type and percentage.



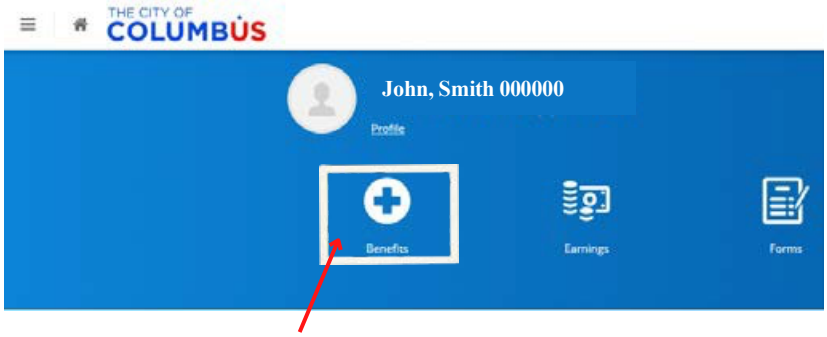
STEP 3. Click Submit.

How to Use Dayforce During HDHP Open Enrollment

STEP 1. Enter Dayforce with your login credentials. User Name is your employee ID number, Initial Password is birth year and last 4- digits of your social security number. *Ex:19501234*

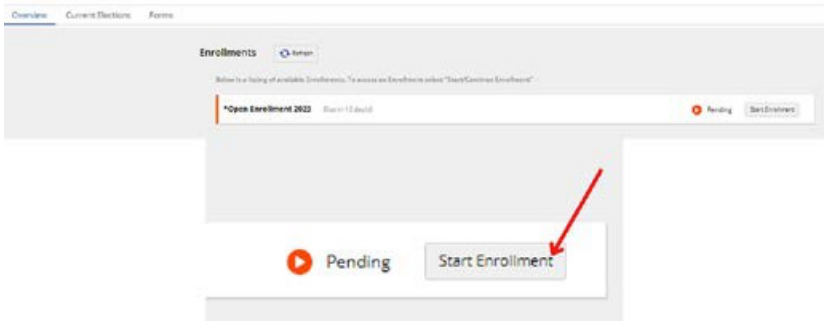
System will ask you to reset your password if this is your first time entering the system (Password must be at least 15 characters or more).

Once logged into Dayforce in the blue banner at the top of the screen select the **Benefits** icon in the top menu bar.



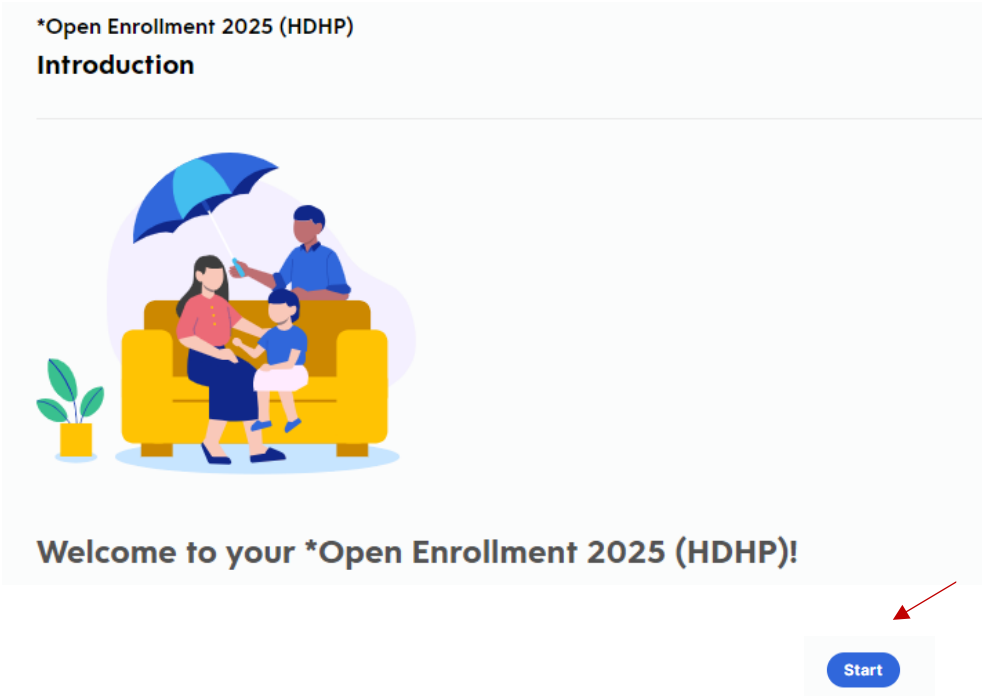
STEP 2. On the Benefit page Overview tab, you will see a list of all active enrollments. Find the Open Enrollment (year) task.

To open and start the enrollment you will click the **Start Enrollment** button to the left of the task.

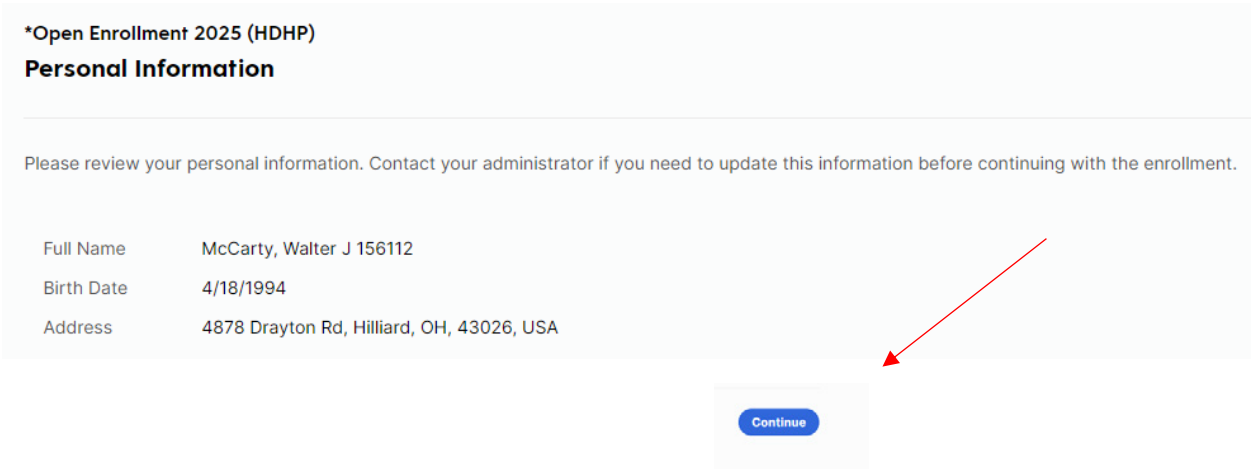


How to Use Dayforce During HDHP Open Enrollment, *continued*

STEP 3. **Review** Open Enrollment Information, Disclosure and Key points. Select **Start**.



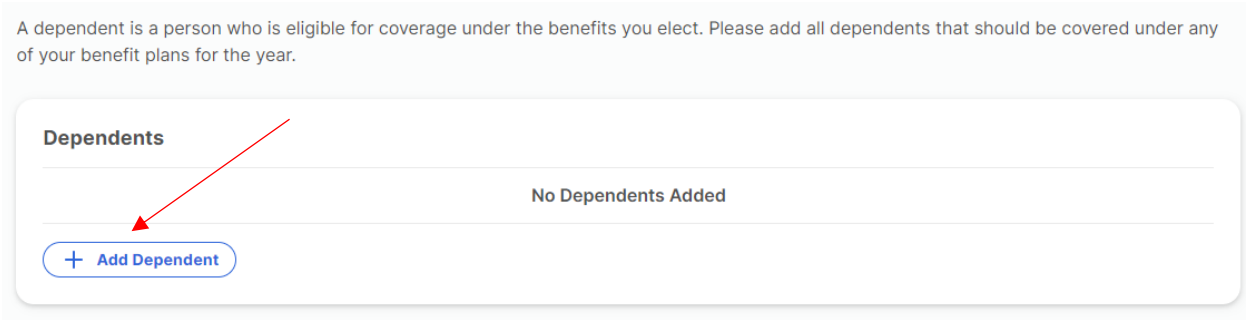
STEP 4. **Review** Personal Information. Select **Continue**.



How to Use Dayforce During HDHP Open Enrollment, *continued*

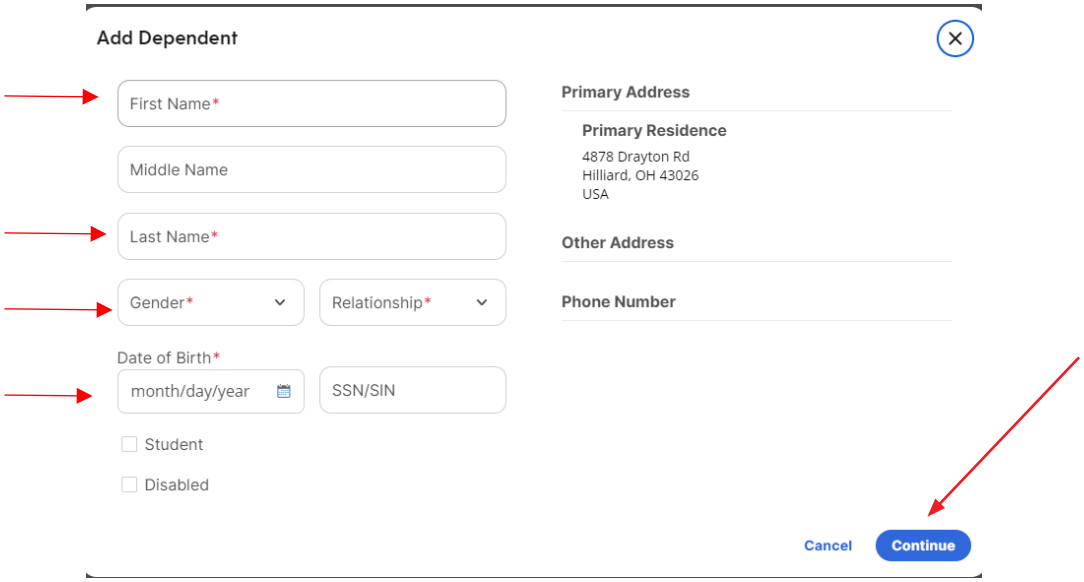
STEP 5. **Review** Current Dependent Information.

To add a new dependent, select the **Add Dependent** button.



STEP 6. Fill out dependent information. Be sure to fill out all required fields:
First Name, Last Name, Gender, Relationship, Birth Date, Social Security Number.

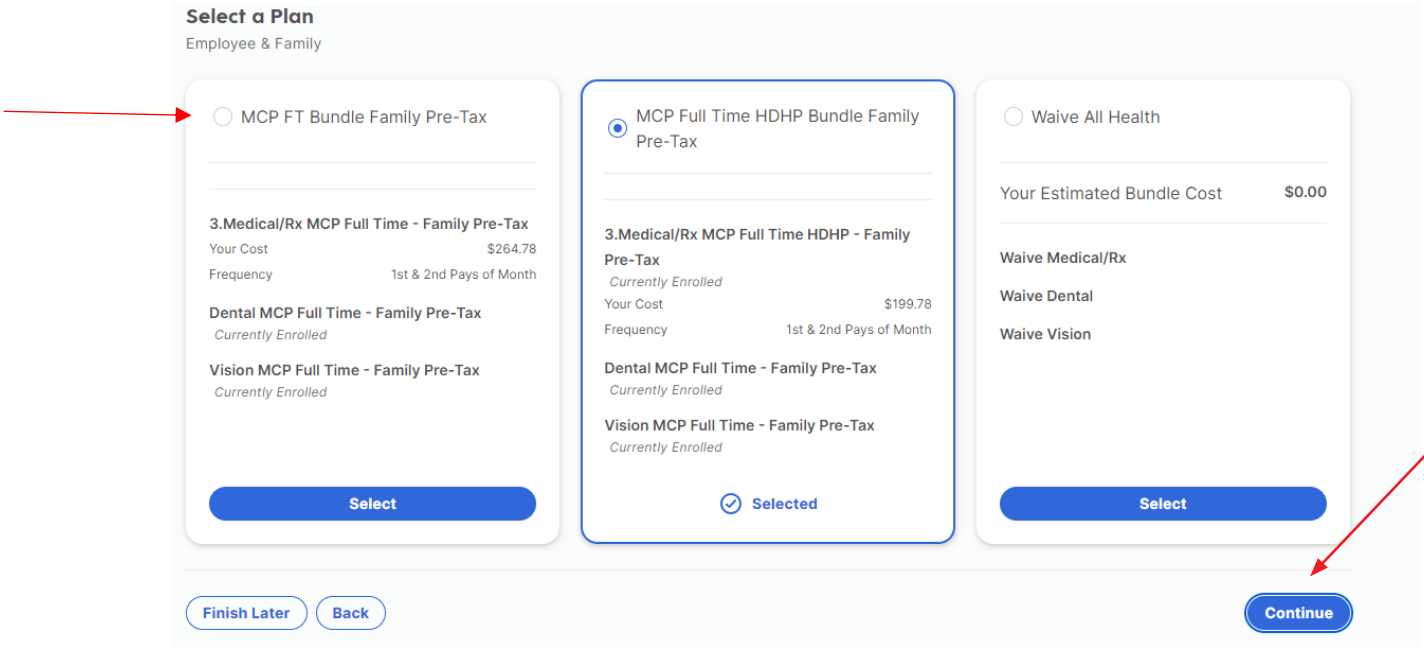
Select **Continue** when done.



How to Use Dayforce During HDHP Open Enrollment, *continued*

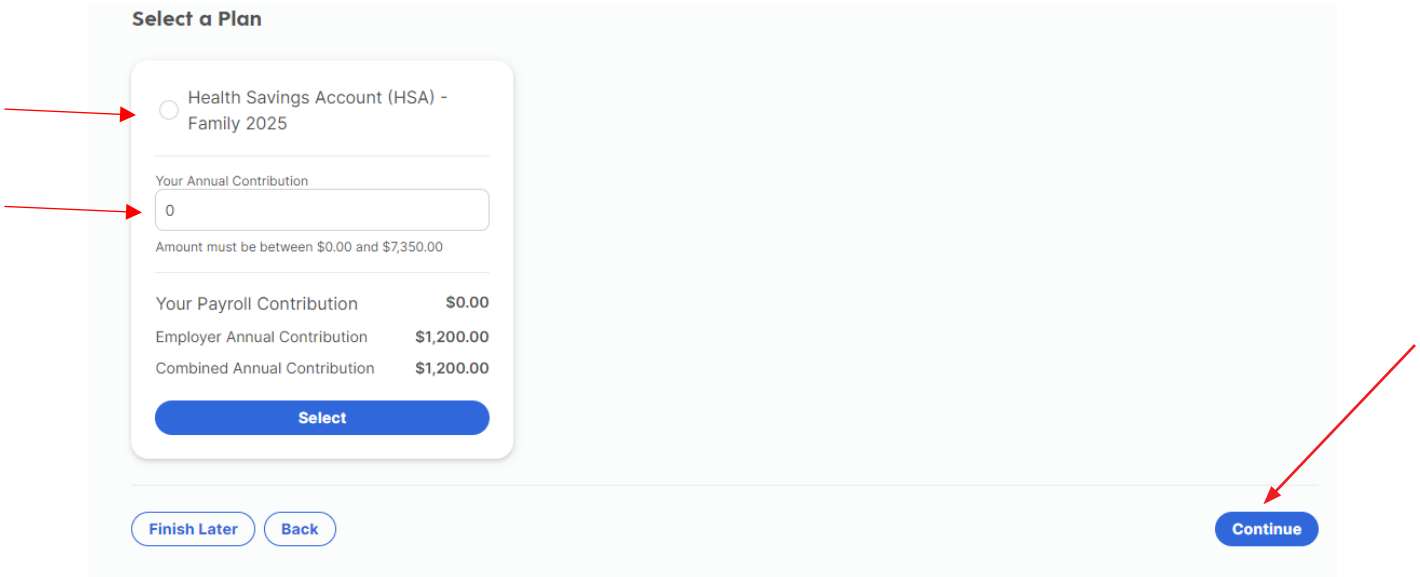
STEP 7. Under the Health Section, **Select** the desired plan option from the list provided. Ensure that you only select one plan option.

Select **Continue** when done.



STEP 8. **Select** HSA and enter a contribution amount.

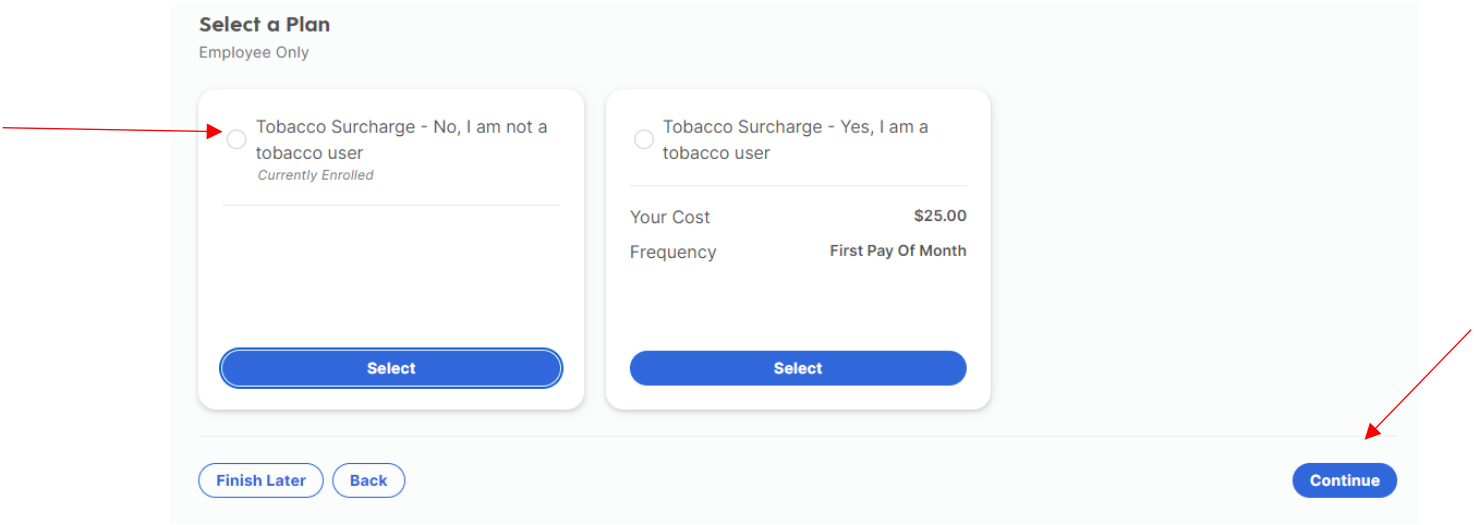
Select **Continue** when done.



How to Use Dayforce During HDHP Open Enrollment, *continued*

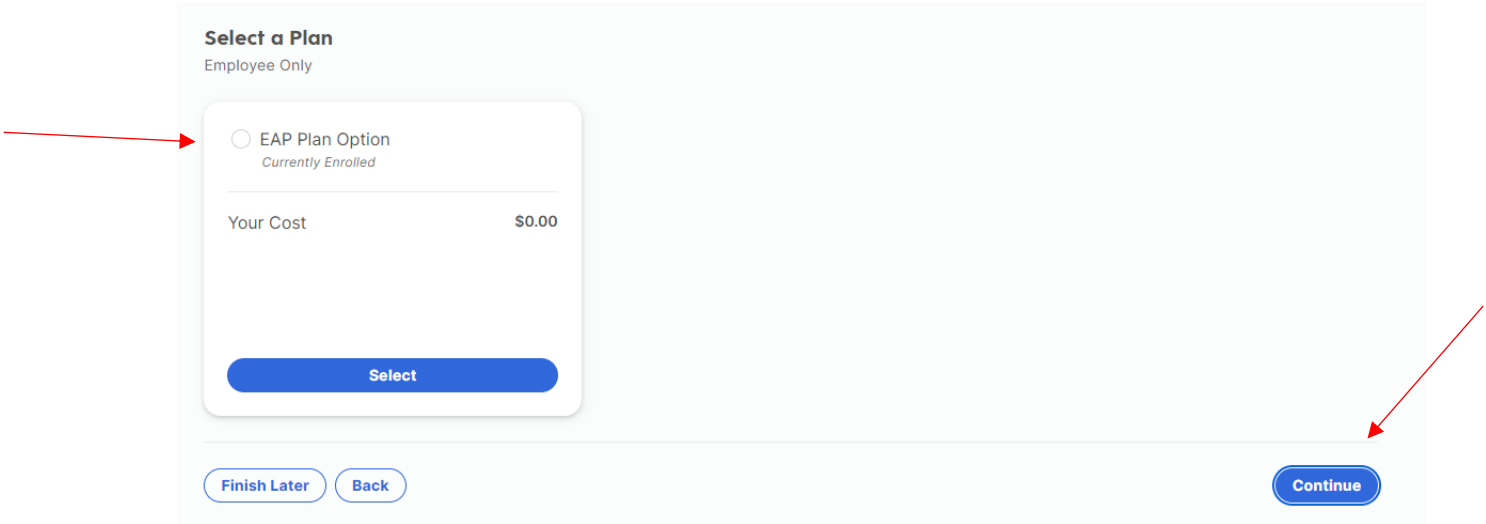
STEP 9. **Select** to make your elections, ensure Tobacco status is selected if populated.

Select **Continue** when done.



STEP 10. **Select** to make elections, ensure EAP Plan is selected.

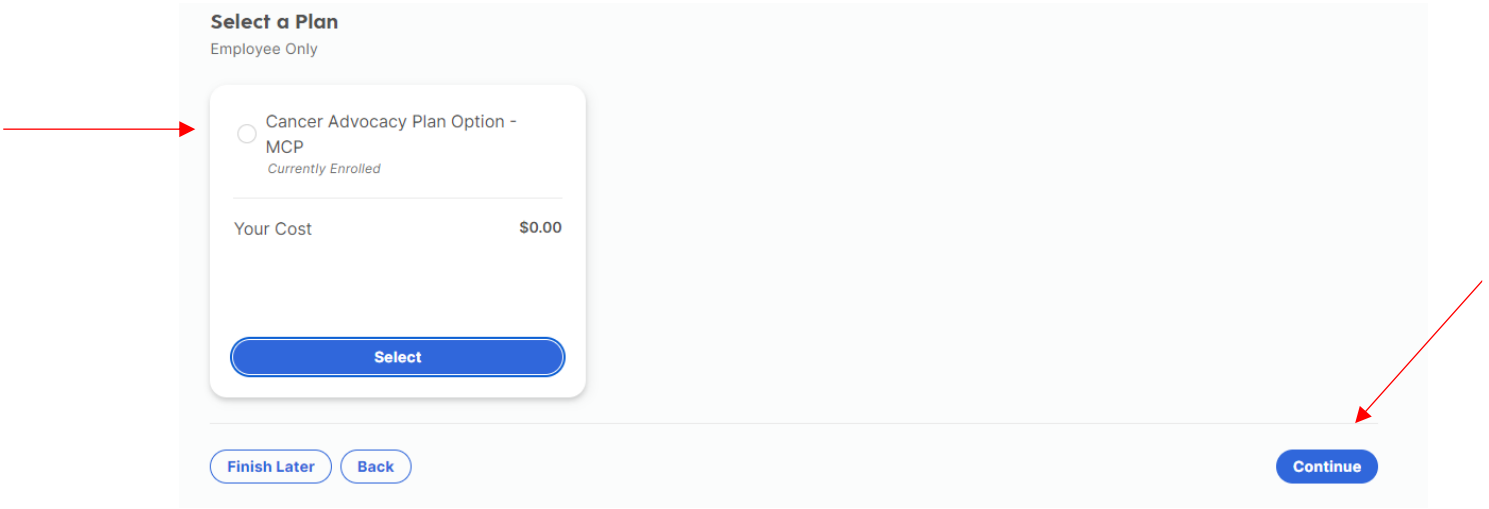
Select **Continue** when done.



How to Use Dayforce During HDHP Open Enrollment, *continued*

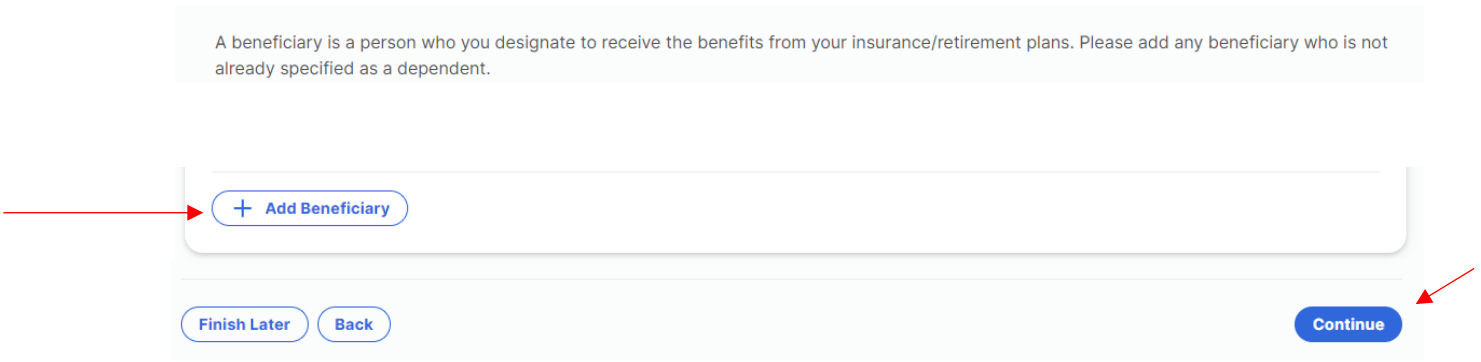
STEP 11. **Select** to make elections, ensure Cancer Advocacy Plan is selected.

Select **Continue** when done.



STEP 12. To add beneficiaries to your life insurance, select **Add Beneficiary** and select beneficiary you would like to include.

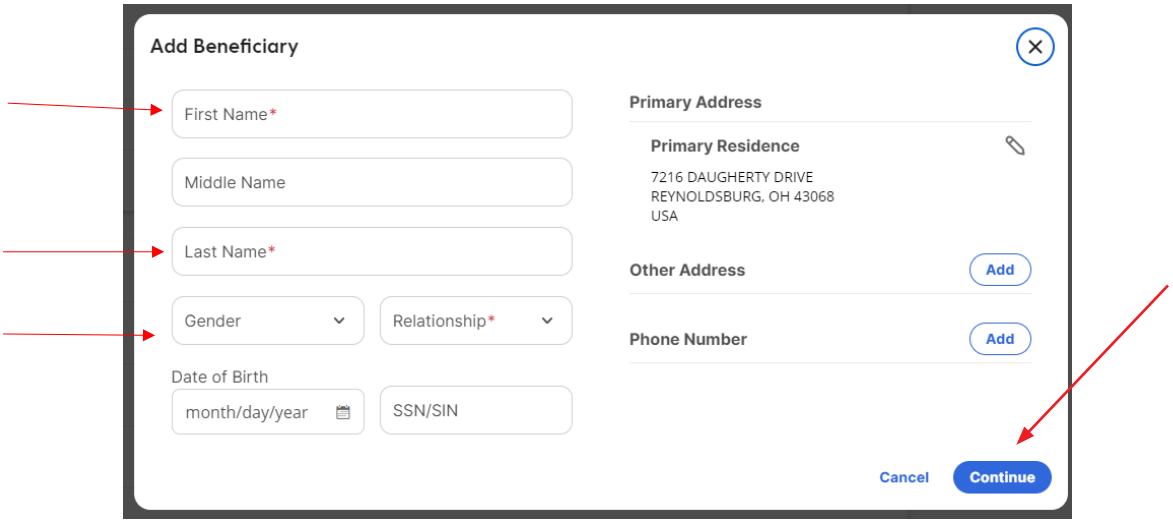
Select **Continue** when done.



How to Use Dayforce During HDHP Open Enrollment, *continued*

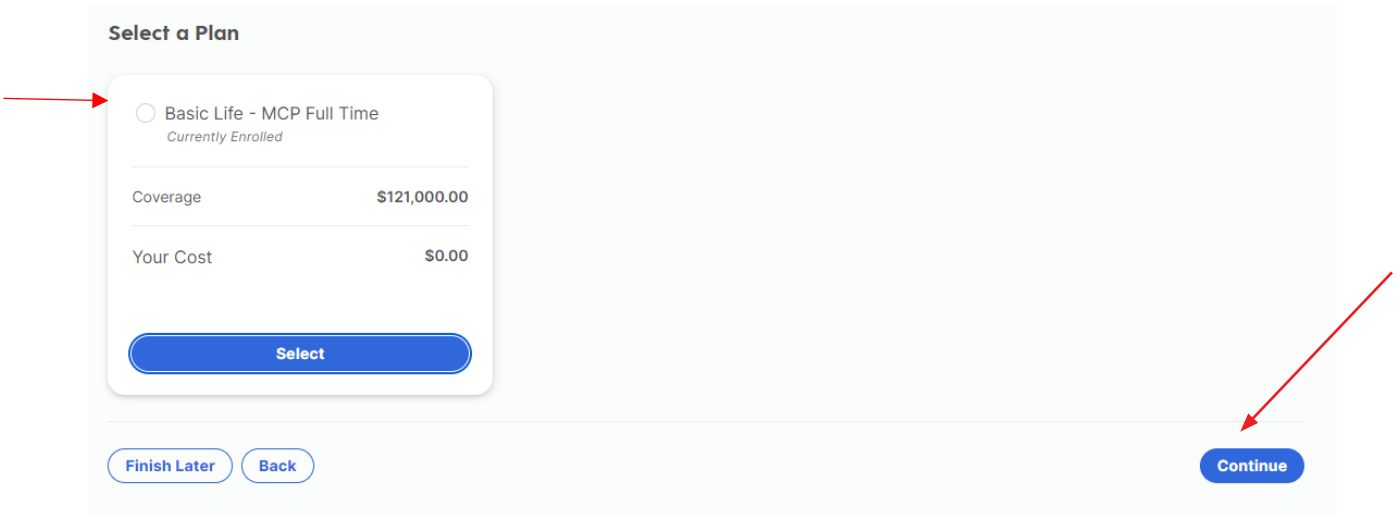
STEP 13. Fill out beneficiary information. Be sure to fill out all required fields: First Name, Last Name, Relationship.

Select **Continue** when done.



STEP 14. Select to make elections, ensure Life Insurance Plan is selected.

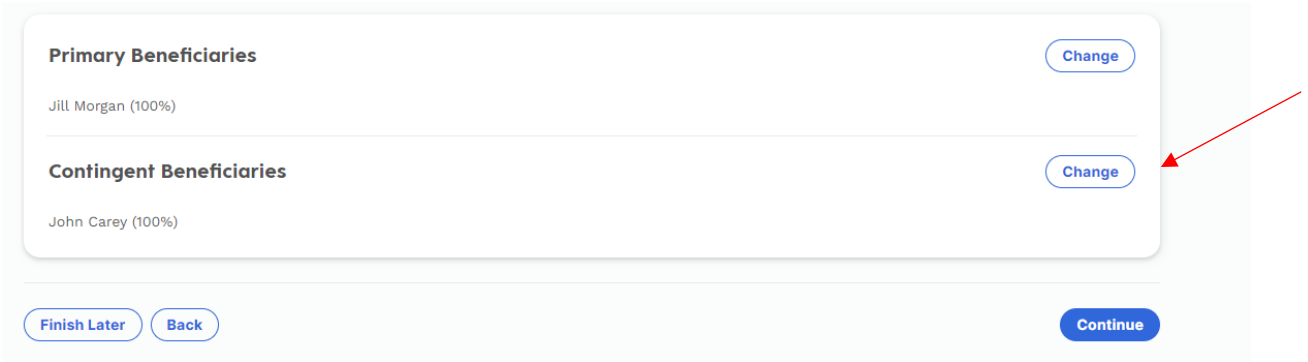
Select **Continue** when done.



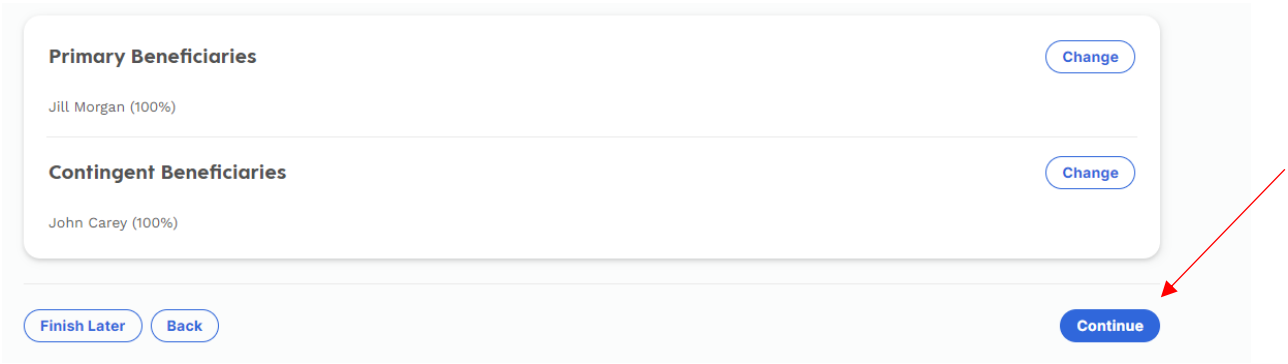
How to Use Dayforce During HDHP Open Enrollment, *continued*

STEP 15. Ensure all Primary beneficiaries add up to 100% and all Contingent beneficiaries add up to 100%.

Select **Change** to make any adjustments to beneficiary percentages.

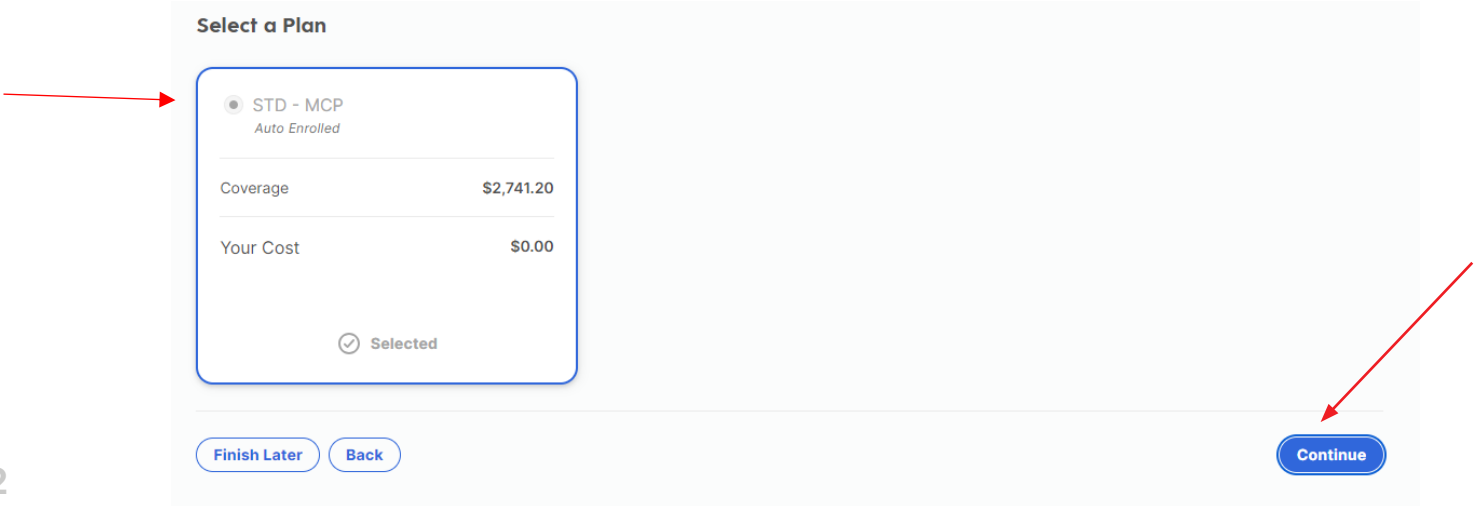


STEP 16. Select **Continue** when done.



STEP 17. **Select** to make elections, ensure STD plan option is selected.

Select **Continue** when done.

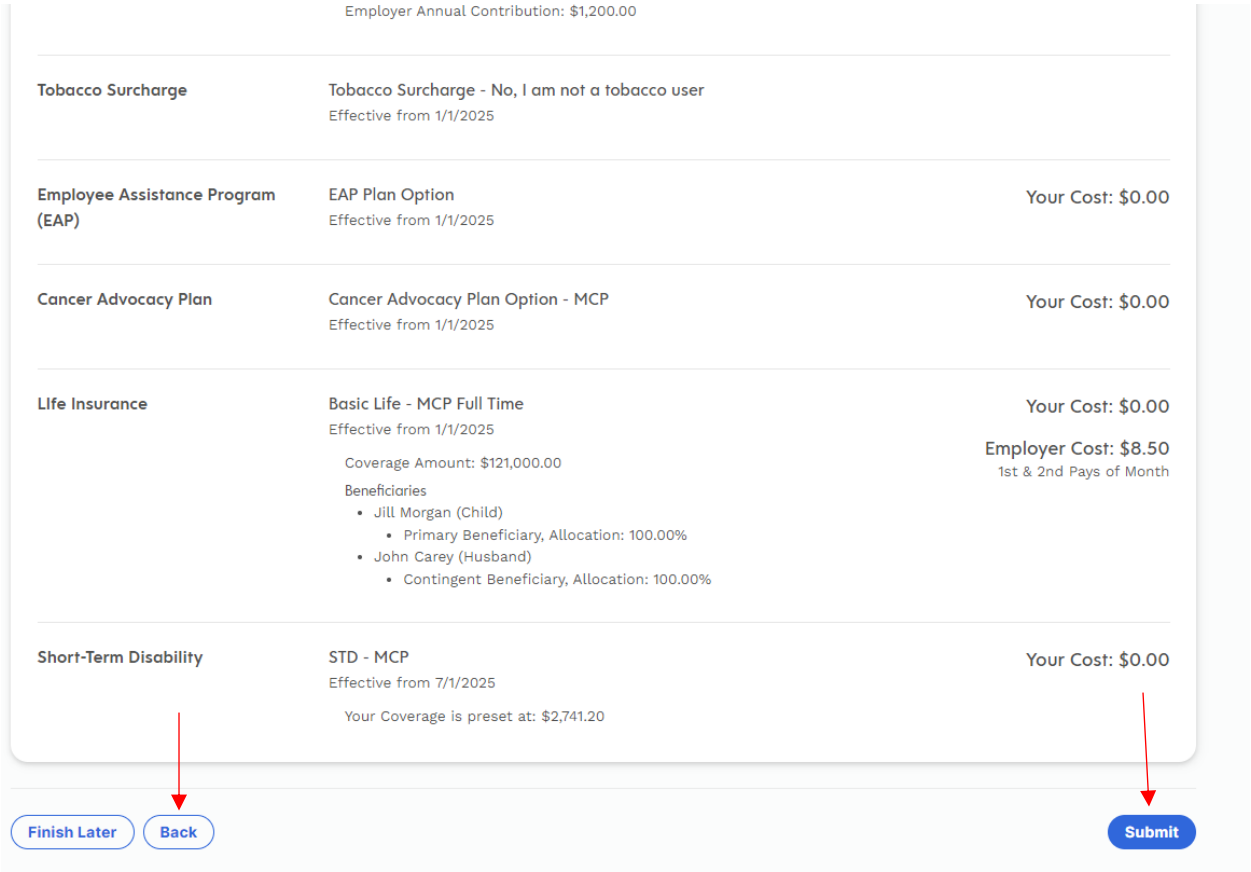


How to Use Dayforce During HDHP Open Enrollment, *continued*

STEP 18. Verify the elections you have made match your intended enrollment.

If you need to make a change, click **Back**.

To submit your enrollment click **Submit Enrollment**.

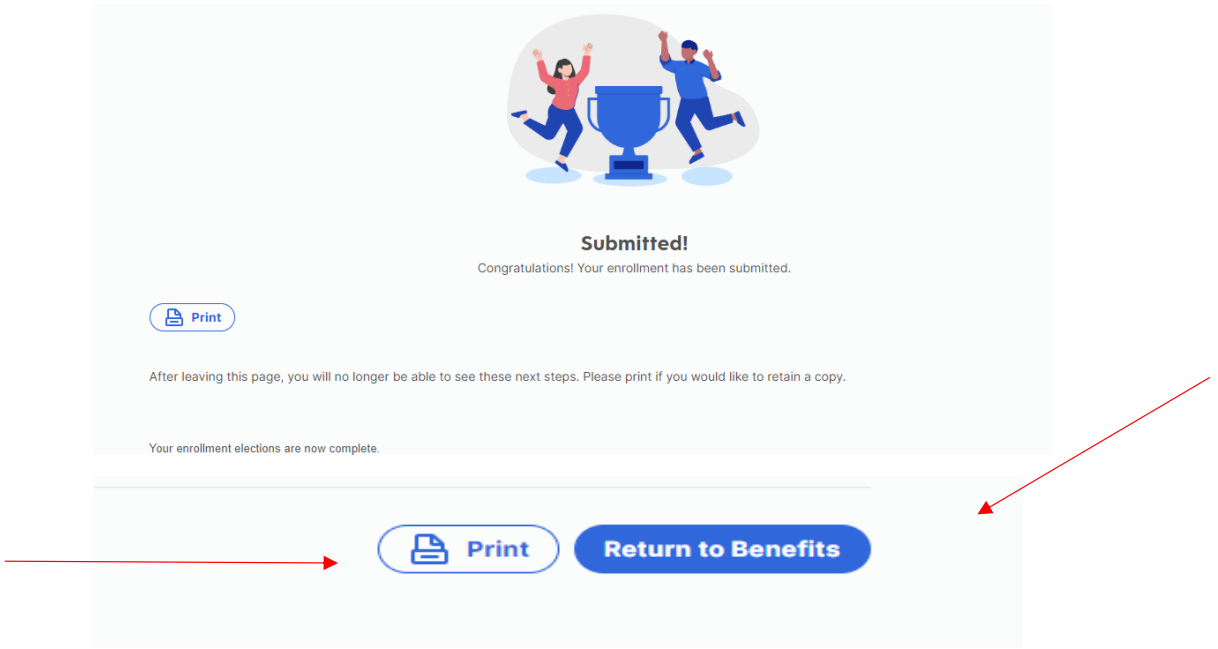


How to Use Dayforce During HDHP Open Enrollment, *continued*

STEP 19. You have successfully completed your Open Enrollment.

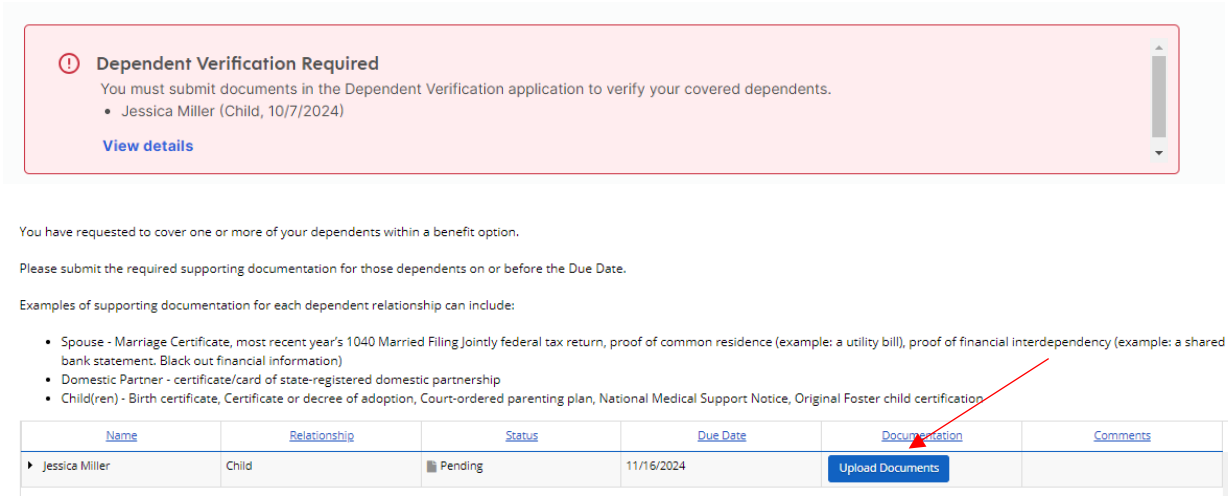
To close out of the enrollment click **Return to Benefits**.

You may print a copy of your elections by selecting **Print**. .



STEP 20. **Upload** Dependent Verification documents.

For full list of acceptable documents see: https://www.columbus.gov/files/sharedassets/city/v/1/human-resources/talent-acquisition/city-of-columbus-definitions-and-required-documents-verification-list.pdf



Required Verification Documents: Adding Dependents

If you are requesting coverage for a dependent (spouse, domestic partner or child), the eligibility of the dependent must be verified before coverage will be approved. To verify a dependent's eligibility, submit the applicable required documents (see dependent types and required documents below).

The required documents must be uploaded to DAYFORCE during the enrollment event:
New Hire: Within 30 days of your date of hire
Qualified Life Event, i.e. marriage, birth, etc.: Within 30 days of the date of the life event
Open Enrollment: No later than the end of the Open Enrollment period

If the required documents are not provided within this time frame coverage will not be approved and the next opportunity to enroll your dependents will be at the next annual Open Enrollment.

READ THIS ENTIRE VERIFICATION LIST BEFORE YOU ENROLL YOUR DEPENDENTS.

Checklist

- ☐ **Enroll your dependent(s) in the Dayforce system.**
  Refer to Navigation Tip Sheet.
- ☐ **Refer to the dependent types on the following pages.**
  Identify the documents required.
- ☐ **Upload documents in the Dayforce system.**
- ☐ **If you need assistance, please contact the Benefits Office.**

Documents must be received within the time frames allowed. Any questions regarding enrollment and eligibility should be directed to the Benefits and Wellness Office.

Address: City of Columbus - Benefits and Wellness Office
77 North Front Street, Ste. 101
Columbus, OH 43215
614-645-8624 8 a.m.-5 p.m., M-F

Fax Number: 614-645-5940

Email Address: EmployeeBenefitsAndWellness@columbus.gov

Website:
columbus.gov/Government/Departments/Human-Resources/Employee-Benefits

Required Verification Documents: Adding Dependents, *continued*

Spouse And Domestic Partner

DEPENDENT TYPE	DEFINITION	REQUIRED DOCUMENT(S)
Spouse	Legal spouse of a covered employee Does not include: - Ex-spouse - *Legally* separated spouse	**<u>One</u> (1) of the following OPTIONS:** **OPTION 1:** Covered employee's most recent Federal Income Tax Return (1040, 1040A or 1040EZ) **as filed with the IRS** listing the spouse - Page 1 **PLUS** signature page if filed hard copy; OR - Page 1 **PLUS** Certificate of Electronic Filing **OPTION 2: Marriage Certificate (court approved certificate or marriage abstract, not license) PLUS one of the following to show current joint tenancy:** - Proof of joint ownership of residence or other real estate; - Proof that covered employee and spouse are both listed on a lease or share the rent of a home or other property; - Joint ownership of a motor vehicle; - Designation of the spouse as a primary beneficiary of the covered employee's life insurance, or retirement benefits; - Utility bill listing both covered employee and spouse (or two separate utility bills at the same address, one listing the covered employee and one listing the spouse).
Domestic Partner	A qualified domestic partner: - must share a permanent residence with the covered employee; - is the sole domestic partner of the covered employee, has been in a relationship with the covered employee for at least six (6) months and intends to remain in the relationship indefinitely; - is not currently married to or legally separated from another person; - shares responsibility with the covered person for each other's common welfare; - is at least 18 years of age and mentally competent; - is not related to the covered employee by blood to a degree of closeness that would prohibit marriage; - is financially interdependent with the covered employee in accordance with the plan requirements.	**Affidavit of Domestic Partnership** **PLUS** **<u>Four</u> (4) of the following documents to show financial interdependency: (one of the 4 documents must substantiate the 6 month history)** - Joint ownership of real estate property or joint tenancy on a residential lease; - Joint ownership of an automobile; - Joint bank or credit account; - Joint liabilities (e.g. credit cards or loans); - A will designating the domestic partner as primary beneficiary; - A retirement plan or life insurance policy beneficiary designation form designating the domestic partner as primary beneficiary; - A durable power of attorney signed to the effect that the covered employee and the domestic partner have granted powers to one another.

Required Verification Documents: Adding Dependents, *continued*

Dependent Child

DEPENDENT TYPE	DEFINITION	REQUIRED DOCUMENT(S)
Natural child (up to age 26)	A natural (biological) child of the covered employee or domestic partner The domestic partner must be enrolled in order to enroll a natural child of the domestic partner unless there is a legal relationship between the employee and the child, i.e. the child was adopted by the employee or the employee has legal guardianship of the child.	**One (1) of the following OPTIONS:** **OPTION 1:** Covered employee or domestic partner's most recent Federal Income Tax Return (1040, 1040A or 1040EZ) **as filed with the IRS** listing the child as dependent - Page 1 **PLUS** signature page if filed hard copy; **OR** - Page 1 **PLUS** Certificate of Electronic Filing **OPTION 2:** Birth Certificate of child **OR** **If one of the OPTIONS above is not available (i.e., when adding a newborn), one (1) of the following:** - Hospital release papers on hospital letterhead - Footprints - Crib Card - Letter from physician or hospital on respective letterhead
Stepchild (up to age 26)	A natural (biological) child of a covered employee's spouse, i.e. a stepchild of the covered employee	**One (1) of the following OPTIONS:** **OPTION 1**: Covered employee or spouse's most recent Federal Income Tax Return (1040, 1040A or 1040EZ) as filed with the IRS listing the stepchild as dependent - Page 1 **PLUS** signature page if filed hard copy; **OR** - Page 1 **PLUS** Certificate of Electronic Filing **OPTION 2**: Birth Certificate of stepchild **If submitting spouse's tax return or birth certificate of stepchild, and the spouse is not covered under the employee's plan, documents proving eligibility of the spouse are also required. Child (up to age 26) covered by a QMCSO- Verbiage is good and verbiage is good for required documents.**
Child (up to age 26) for whom the employee, spouse or domestic partner is legal guardian.	A child for whom legal guardianship has been awarded to the covered employee, spouse or domestic partner. The domestic partner must be covered in order to cover a child for whom the domestic partner has been awarded legal guardianship unless there is a legal relationship between the employee and the child, i.e. the employee has legal custody of the child.	**One (1) of the following OPTIONS:** **OPTION 1:** Covered employee, spouse or domestic partner's most recent Federal Income Tax Return (1040, 1040A or 1040EZ) as filed with the IRS listing the child as dependent - Page 1 **PLUS** signature page if filed hard copy; **OR** - Page 1 **PLUS** Certificate of Electronic Filing **OPTION 2:** Court documents signed by a judge verifying legal custody of the child **If submitting spouse's tax return or court documents of legal custody, and the spouse is not covered under the employee's plan, documents proving eligibility of the spouse are also required.**

Required Verification Documents: Adding Dependents, *continued*

Dependent Child

DEPENDENT TYPE	DEFINITION	REQUIRED DOCUMENT(S)
Adopted child (up to age 26)	A legally adopted child of the covered employee, spouse or domestic partner, includes children placed in anticipation of a legal adoption The domestic partner must be covered in order to cover an adopted child of the domestic partner unless there is a legal relationship between the employee and the child, i.e. the child was adopted by the employee as well, or the employee has legal guardianship of the child.	**One (1) of the following OPTIONS:** **OPTION 1:** Covered employee, spouse or domestic partner's most recent Federal Income Tax Return (1040, 1040A or 1040EZ) as filed with the IRS listing the child as dependent - Page 1 **PLUS** signature page if filed hard copy; **OR** - Page 1 **PLUS** Certificate of Electronic Filing **OPTION 2:** Court documents for the adopted child from a court of competent jurisdiction **OPTION 3:** International adoption papers from country of adoption **OPTION 4:** Papers from the adoption agency showing intent to adopt **If submitting spouse's tax return, court documents or adoption papers, and the spouse is not covered under the employee's plan, documents proving eligibility of the spouse are also required.**
Child (up to age 26) covered by a QMCSO	A child for whom health care coverage is required through a Qualified Medical Child Support Order (QMCSO).	**One (1) of the following OPTIONS:** **OPTION 1:** Court documents signed by a judge **OPTION 2:** Medical support orders issued by a State agency

Disabled Dependent

DEPENDENT TYPE	DEFINITION	REQUIRED DOCUMENT(S)
Disabled Dependent, age 26 or older	A dependent incapable of self-sustaining employment because of a mental or physical disability that began while the dependent was eligible.	**One of the required documents for the applicable dependent child definition type above.** (See DEPENDENT CHILD section) **PLUS** **Proof of Disability Beyond Limiting age Certification**

Resources To Obtain Documents

- **Birth Certificates & Marriage Licenses:** http://www.odh.ohio.gov/vitalstatistics/vitalstats.aspx
- **Children born outside the United States:** http://www.state.gov
- **Letters or Transcripts:** call the school registrar's office to request a letter or transcript for schools, colleges, and universities.

Special Open Enrollment Things to Remember

- Members will have an **Open Enrollment** period from October 28th through November 30th, 2024 for the HDHP with HSA with an effective date of January 1, 2025.
- Employees that enroll during **Open Enrollment** period can only enroll in the HDHP with HSA, unless the employee is returning to the Traditional PPO. The effective date will be January 1, 2025.
- Employees that DO NOT enroll in the HDHP with HSA, will complete their **2025 Open Enrollment** in February 2025.
- Employees cannot opt out of the HDHP with the HSA during February 2025 **Open Enrollment** period.
- Employee Open Enrollment elections are irrevocable unless the employee has a qualifying life event.
- Employees with Qualifying Life Events occurring after January 1, 2025 will have 30 days to enter the requested change in the Dayforce employee self-service system.
- Updating existing dependents during Open Enrollment is not allowed. Updates to dependents will need to be processed by the Benefits Office.
- Qualifying Life Events during this Open Enrollment will need to be processed first, then the employee completes Open Enrollment elections.
- Employees can only change Healthcare Plan Designs during Open Enrollment, unless the employee is moving from a waive status.
- Employees are required to make an active election to change health care plans.
- Employees that enroll in the HDHP with HSA, will need to also open a health savings bank account with CME.
- Employees must elect a current plan year HSA **each** year during open enrollment. You can periodically adjust if needed.
- Employees will need to complete both an active election into the HDHP and make an annual Health Savings Account election from $0 to IRS annual limit.Without opening a 2025 HSA, the City is unable to make the employer deposits in January and July.
- Employees will contribute to the health savings account 24 times annually – first and second pay of the month.
- City of Columbus will contribute in January and July to the employee's single or family account. See union agreement or Ordinance for more details.
- ALL EMPLOYEES are asked to designate your life insurance beneficiaries while completing your open enrollment.
- **Watch your mail – Employees will receive new ID cards if they newly elect HDHP with HSA and a debit card.**

Where do I get more information?

- Additional Information available on the Employee Benefits Website in the Open Enrollment section.

Important information on the following pages:

CME Federal Credit Union HSA Account Instructions

Pages 60-61

Step by Step – Online Instructions for the Health Savings Account for CME Federal Credit Union

Visit our website: www.cmefcu.org

Click on "Open account or Apply for a Loan" in the top section of our home page. It will ask for your name and mobile number. Once you add your name and mobile number you will get a text from CME.

Scroll down to ACCOUNTS

1. In the Left column under "Accounts" you will choose either "New Members Apply Here" or if you are an existing Member "Existing Members Apply Here."

Eligibility & Products (For New Members):

1. Please enter your county you live/work/worship in from the first drop down box.
2. Once you click on your County, it will populate a second drop down box.
3. From the second drop down box, please choose your Employer.
4. Scroll down to Required/Available Products.

Required Products:

1. After you add Advantage Share under Required Products (blue circle with + on the right hand side) then click "add account" it will default to estatement.
2. Under Available Products, please click on the Health Savings Account (blue circle with + on the right hand side) it will direct you to Select feature "HSA debit card" click on that box.
3. HSA debit cards will arrive in 7-10 business days in an unmarked, white envelope. PIN mailed separately.
4. Once you click on Health Savings Account you will be taken to another page that lets you click on "select feature" "HSA Debit Card" then from the next drop down box, indicate if you have Family or Individual Health Insurance. Please click on one of those two options.
5. Next drop down, please choose your Marital Status.
6. Answer the questions below "How many additional cardholders would you like to add to your Health Savings Account".
7. Once you determine if you want additional cards, you will need that person's date of birth and social security number.
8. After completing that section, please click on "add account". Then you will be directed back to the "required products screen."
9. If that is all the accounts you are interested in, please click on "Continue".

Eligibility & Products (For Existing Members):

1. It will ask you "Available Products" for your product to add to your existing Membership.
2. After you have chosen, please click on continue. It will ask you for your personal information.
3. Once you put your social security number in, it will automatically connect with your existing account.

Step by Step – Online Instructions for the Health Savings Account for CME Federal Credit Union, *continued*

Tell Us About Yourself/Personal Information:

1. Once you get to the Occupancy stage, if you have lived someplace less than two years it will require you to put your previous address in.
2. After you add your personal information, click on "continue".
3. Click on the blue box that applies, Continue without Co-Applicant or Continue with Co-Applicant.
   a. Please note, you do not have to add a spouse or co-applicant to an account in order to get them a debit card that's tied to the account.

Funding:

1. In this section please choose the following – "Mail A Check" – but don't mail a check, we will deposit the first $5 as a thank you for choosing CME.
2. After clicking on "mail a check," please click "continue"

Review and Submit:

1. Please read over and confirm your information is all correct.
2. One last question: How did you hear about CME FCU?

Read, Sign and Submit:

1. There will be two boxes, Receive communication electronically and Privacy Policy, to read over and then hit "I agree."
2. Once we receive your online application, we will process it. If we need additional information you will receive an email from us.

Please watch for an email from DocuSign to complete the process – *this is how we capture your electronic signature. The debit card(s) will be mailed out within 7-10 business days and will arrive in a plain white unmarked envelope.*

THE CITY OF
COLUMBUS
ANDREW J. GINTHER, MAYOR

DEPARTMENT OF
HUMAN RESOURCES

benefits & wellness programs

THE CITY OF
COLUMBUS
ANDREW J. GINTHER, MAYOR