Summary of Material Modifications (SMM)

City of Columbus Group Health Benefit Plan

Group Number: 706539

Effective Date of this SMM: **April 2, 2025**

A Summary Plan Description (SPD) was published effective **January 1, 2025**. This SMM to the Plan SPD is issued by the Plan Sponsor as described below.

Because this SMM is part of a legal document, the Plan Sponsor wants to give you information about the document that will help you understand it. Certain capitalized words have special meanings. The definitions for these words are in the SPD in Section 14, *Glossary* and Section 15, *Outpatient Prescription Drugs*.

What are the Modifications to the Plan?

- Coverage for hearing aids is now included for all plans.
- Rehabilitation services copays have been updated for physical therapy, occupational therapy, and manipulative treatment for the Copay plans.

These modifications and clarifications are intended as a summary to supplement the SPD. It is important that you keep this SMM with your *SPD* since this material plus the *SPD* is your complete SPD. In the event of any discrepancy between this SMM and the *SPD*, the provisions of this SMM shall govern.

Impacted Plans:

Sets 001/008	AFSCME 1632 FT and PT Choice Plus Plans
Set 002	FOP Choice Plus Plan
Set 003	IAFF Choice Plus Plan
Sets 004/014	CWA FT and PT Choice Plus Plans
Sets 005	OLC Choice Plus Plan
Sets 006/007	MCP FT and PT Choice Plus Plans
Set 010	IAFF HDHP Choice Plus Plan
Sets 012/013	AFSCME 2191 FT and PT Choice Plus Plans
Sets 018/019	MCP HDHP FT and PT Choice Plus Plans
Set 020	OLC HDHP Choice Plus Plan
Sets 021/022	AFSCME 2191 HDHP FT and PT Choice Plus Plans
Sets 023/024	CWA HDHP FT and PT Choice Plus Plans
Set 026	FOP HDHP Choice Plus Plan
027/029	AFSCME 1632 HDHP FT and PT Choice Plus Plans

SECTION 5 - PLAN HIGHLIGHTS

Payment Terms and Features

Applies to Sets 001, 004, 005, 006, 007, 008, 012, 013, and 014 only.

Plan Features	Network Amounts	Non-Network Amounts
Copays		
In addition to these Copays, you may be responsible for meeting the Annual Deductible for the Covered Health Services described in the chart on the following pages		
▪ Rehabilitation Services	$20/$30	Not Applicable

Schedule of Benefits

Applies to Sets 001, 002, 003, 004, 005, 006, 007, 008, 012, 013, and 014 only.

Covered Health Services[1]	Benefit *(The Amount Payable by the Plan based on Eligible Expenses)*	
	Network	Non-Network
Hearing Aids See Section 6, *Additional Coverage Details*, for limits.	100%	60% after you meet the Annual Deductible

Applies to Sets 010, 018, 019, 020, 021, 022, 023, 024, 026, 027, and 029 only.

Covered Health Services[1]	Benefit *(The Amount Payable by the Plan based on Eligible Expenses)*	
	Network	Non-Network
Hearing Aids See Section 6, *Additional Coverage Details*, for limits.	100% after you meet the Annual Deductible	60% after you meet the Annual Deductible

Applies to Sets 001, 004, 005, 006, 007, 008, 012, 013, and 014 only.

Covered Health Services[1]	Benefit *(The Amount Payable by the Plan based on Eligible Expenses)*	
	Network	**Non-Network**
Rehabilitation Services - Outpatient Therapy and Manipulative Treatment		
▪ Office	100% after you pay a Copayment of $20 per visit for physical therapy, occupational therapy and Manipulative Treatment 100% after you pay a Copayment of $30 per visit for all other rehabilitation services	60% after you meet the Annual Deductible
▪ Outpatient	100% after you pay a Copayment of $20 per visit for physical therapy, occupational therapy and Manipulative Treatment 80% after you meet the Annual Deductible for all other rehabilitation services	60% after you meet the Annual Deductible

SECTION 6 – ADDITIONAL COVERAGE DETAILS

Applies to all sets.

Hearing Aids

The Plan pays Benefits for hearing aids required for the correction of a hearing impairment (a reduction in the ability to perceive sound which may range from slight to complete deafness). Hearing aids are electronic amplifying devices designed to bring sound more effectively into the ear. A hearing aid consists of a microphone, amplifier and receiver.

Benefits are available for a hearing aid that is purchased through a licensed audiologist, hearing aid dispenser, otolaryngologist or other authorized provider. Benefits are provided for the hearing aid and associated fitting charges and testing.

If more than one type of hearing aid can meet your functional needs, Benefits are available only for the hearing aid that meets the minimum specifications for your needs. If you purchase a hearing aid that exceeds these minimum specifications, the Plan will pay only the amount that the Plan would have paid for the hearing aid that meets the minimum specifications, and you will be responsible for paying any difference in cost.

Benefits do not include bone anchored hearing aids. Bone anchored hearing aids are a Covered Health Service for which Benefits are available under the applicable medical/surgical Covered Health Services categories in this section only for Covered Persons who have either of the following:

- Craniofacial anomalies whose abnormal or absent ear canals preclude the use of a wearable hearing aid.
- Hearing loss of sufficient severity that it would not be adequately remedied by a wearable hearing aid.

Any combination of Network Benefits and Non-Network Benefits is limited to $2,500 per hearing impaired ear. Benefits are limited to a single purchase (including repair/replacement) per hearing impaired ear every 48 months. Benefits are further limited to children age 21 and under.

SECTION 8 - EXCLUSIONS AND LIMITATIONS: WHAT THE MEDICAL PLAN WILL NOT COVER

Applies to all sets.

Devices, Appliances and Prosthetics

The following exclusion applies:

9. All over-the-counter medical equipment or devices defined as items which can be typically purchased at (including, but not limited to) a local pharmacy, supermarket, internet site, general publication or medical supply storefront and do not require a Physician's prescription for purchase. This exclusion does not apply to over-the-counter hearing aids for which Benefits are provided as described under Hearing Aids in Section 6: Additional Coverage Details.

Vision and Hearing

The following exclusion applies:

6. Bone anchored hearing aids except when either of the following applies:

    - For Covered Persons with craniofacial anomalies whose abnormal or absent ear canals preclude the use of a wearable hearing aid.
    - For Covered Persons with hearing loss of sufficient severity that it would not be adequately remedied by a wearable hearing aid.

    The Plan will not pay for more than one bone anchored hearing aid per Covered Person who meets the above coverage criteria during the entire period of time the Covered Person is enrolled in this Plan. In addition, repairs and/or replacement for a bone anchored hearing aid for Covered Persons who meet the above coverage are not covered, other than for malfunctions.

7. Over-the-counter hearing aids.

The following exclusion no longer applies:

4. Purchase cost and associated fitting and testing charges for hearing aids, Bone Anchor Hearing Aids (BAHA) and all other hearing assistive devices.