THE CITY OF
COLUMBUS
ANDREW J. GINTHER, MAYOR

DEPARTMENT OF
HUMAN RESOURCES

IAFF Special Open Enrollment 2020:

Review the enclosed information to learn more about:

Shifting focus — from managing your health benefits to managing your health.

Most traditional PPO plans focus on managing your health benefits. The high deductible health plan with an HSA focuses on managing your health by encouraging you to:

- Take a more active role in your healthcare buying decisions.
- Make healthier choices and seek quality care.

A Health Savings Account (HSA).

You have the option of opening an HSA for plan year 2020. An HSA is a personal bank account that you own. You can use the HSA to save money, federal income-tax free, to pay for qualified medical expenses. You can even save the money for a future need — even into retirement.

Tools and services to make informed decisions.

This plan gives you access to resources for information about cost and care options available on **myUHC.com**.

Why this matters.

The more you know, the better decisions you can make about medical treatments and spending.

UnitedHealthcare®

Health Savings Accounts: Clearing up the Myths

If you have always taken the PPO plan, the HSA plan may seem confusing. There are many myths about Health Savings Account (HSA) plans and how they work.

"Are HSA plans only good for healthy, singles or families with no kids?"

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

"How can my HSA plan 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 HSA plan, 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 limit. Once you reach your out-of-pocket limit, 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. 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 to keep even if you change jobs or health plans, or retire.

"HSA plans 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% 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 limit 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 network doctors.

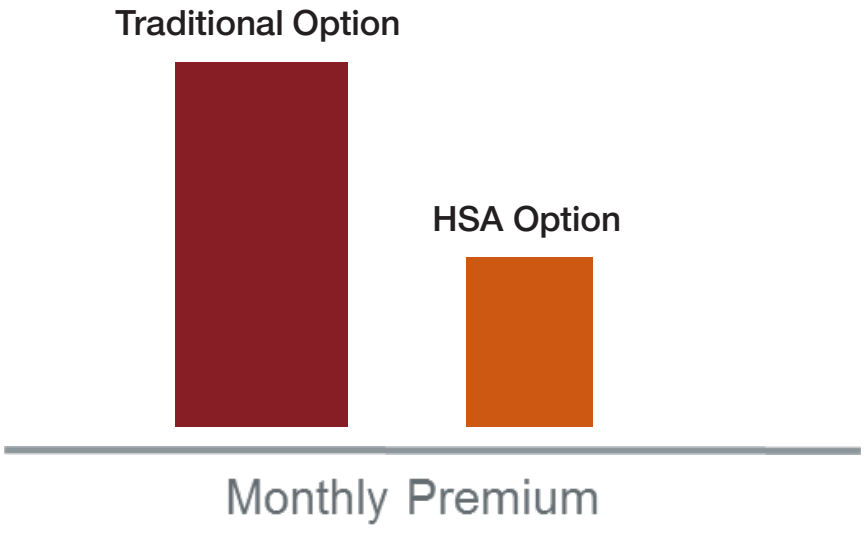
UnitedHealthcare Medical Plans

IAFF Employees have two plans to choose from for 2020.

- **Qualified High Deductible Health Plan (HDHP)** with a **Health Savings Bank Account (HSA)**
- **Traditional PPO Plan** with a lower medical deductible and first dollar pharmacy co-pays

Premium Comparison

The HSA has a lower monthly premium than the Traditional PPO Plan.



Your per pay contribution is less if you choose the HSA, which adds up to BIG savings. Think about depositing your premium savings into your HSA Account!

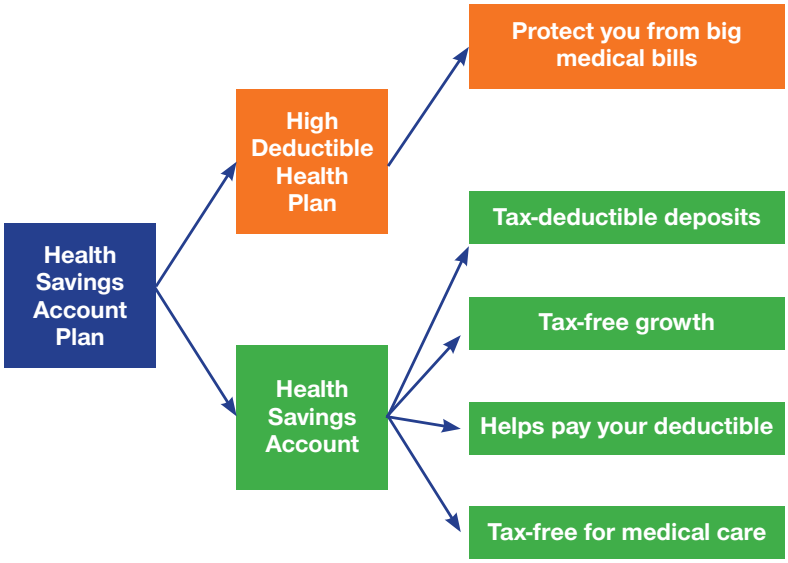
Annualized Premium Difference between PPO & HDHP Plans

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

How does an HSA work?

An HSA is two parts, first is a UHC Medical Plan that covers all the same services that the Traditional PPO does, you can use all the same doctors — it just has a higher deductible and without flat-dollar copays for prescriptions.

The second part is the Health Savings Bank Account. The HSA Bank Account is owned by the employee who can deposit money into the account in addition to the money the City of Columbus is contributing. The money deposited into the HSA Account is tax free and the money remains tax free as long as it's spent on a qualified medical expense. The money is typically spent to help pay for your deductible, but some people use it as a way to save money for future medical expenses. Your money can grow interest, and even the interest is tax free.



HSA Bank Accounts

What do I need to know?

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

You don't have to pay federal income tax on:

- Deposits you, or others make into your HSA
- Money you spend from your HSA for qualified medical expenses
- Interest earned on the HSA

Building a Balance in my HSA Bank Account

Where does the money come from?

The City of Columbus is making a deposit into your HSA bank account in 2020.

- $500 for an employee only
- $1000 for a family

You will pay less monthly premium if you select the HSA in 2020.

Instead of taking the premium savings into your paycheck, consider depositing the money into your HSA bank account.

- $50 per month for an employee only, $600 annually.
- $130 per month for a family, $1560 annually.

By depositing the premium savings plus the City of Columbus's annual contribution, you can have your HSA account partially funded without additional money coming out of your pocket.

	Single	Family
Annual premium savings if you take the HSA option	$600	$1,560
City of Columbus Annual HSA Contribution	$500	$1,000
Total HSA Contribution	$1,100	$2,560

In addition to the premium savings and the City's contribution into your HSA account, please consider contributing your sick leave reciprocity (SLR) during the month of November as a deposit to the HSA up to the IRS maximum. Your reciprocity sick leave can be direct deposited into your CME HSA bank account allowing IAFF employees to maximize their tax advantaged account.

Health Savings Bank Account

What are my 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

In 2020, single coverage can contribute up to $3,550 per year and family coverage can contribute up to $7,100 per year.

Additional Funding

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

Employer Deposits for 2020

- $500 for Single Coverage
- $1,000 for Family Coverage
- Please consider adding your reciprocity sick leave deposit – Not to exceed the annual IRS limit based on 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.

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 IAFF members who took the HSA option in both 2020 & 2021)

e-Contribute

Contact CME to set up an electronic transfer from a CME account or from an account at another financial institution.

Paying for Non-Qualified Expenses

What happens if I spend the money on a non-qualified medical expenses, 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 age 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 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

HSA Qualified Medical Expenses

*What does the IRS consider a qualified medical expenses? 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

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, but account is not eligible for deposits/card use until January 2020
- Complete step-by-step details provided for Current Members and New Members
- Employee will receive electronic documents for e-signing from a secure site called DOCUSIGN
- Cards will arrive 10-14 business days from completion of DOCUSIGN in an unmarked envelope for security purposes. PIN will arrive separately.
- Option to open in local branches, if preferred.

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 opening. A PIN will be sent separately.

Open Your HSA Bank Account Today!

Page 25 *has complete instructions for how* ***new*** *CME Federal Credit Union Members can open an HSA Bank Account.*

Page 27 *has instructions for* ***existing*** *CMEFCU members.*

Open Enrollment: Comparison of In-Network Plan Designs

	PPO In-Network	HDHP w/HSA In-Network
Annual In-Network Deductible		
Single	$300	$1,500
Family	$300 single/$600 family (Embedded)	$3,000 (Non-Embedded)
Annual In-Network Out-of-Pocket Maximum		
Single	$700	$3,000
Family	$700 single/$1,200 family (Embedded)	$6,000 (Non-Embedded)
Coinsurance	20% after deductible	20% after deductible
Preventive Care Services In-Network (Following ACA age/gender guidelines)	0%	0%
Office Visits	20% after deductible	20% after deductible
Urgent Care	20% after deductible	20% after deductible
Emergency Room Services	20% after deductible	20% after deductible
Virtual Visits	20% after deductible	20% after deductible
Prescription Drugs	$5/$15/$30 (Retail) $12.50/$25/$60 (Mail Order) Rx only OOPM Single - $2,000 Rx only OOPM Family - $4,000	20% after deductible (Check available OptumRx drug cost resources after January 1, 2020)

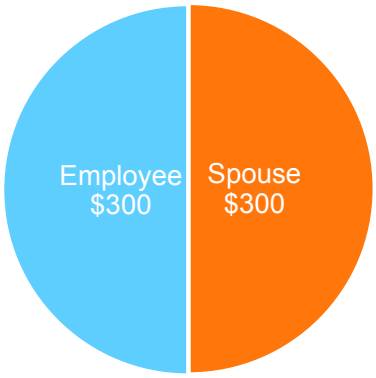
Please note these are in-network benefits; just like today, both plans have a separate, higher expense out-of-network schedule of benefits to you.

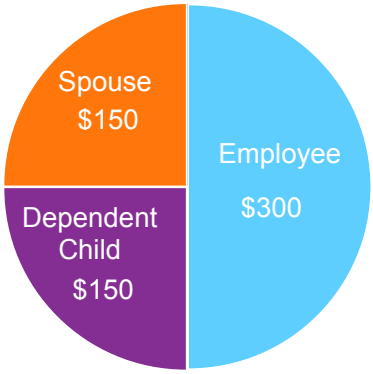
Embedded vs Non-Embedded Deductible

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.

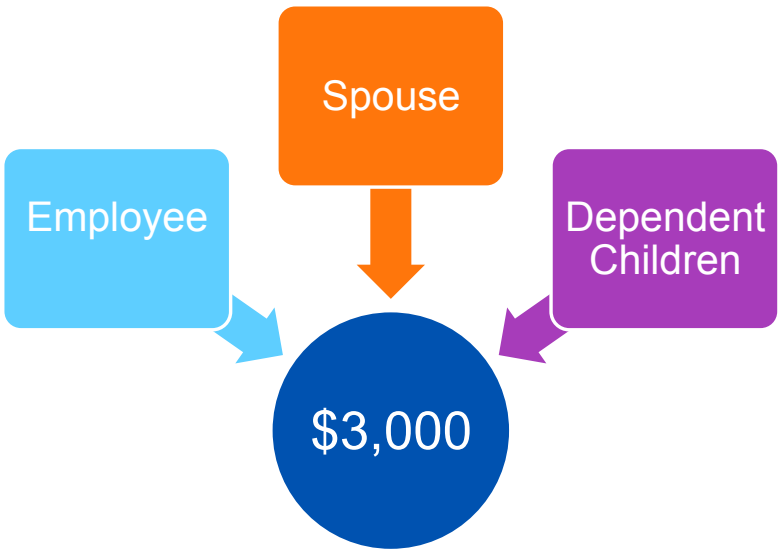




What does "Non-Embedded" deductible mean?

High Deductible Health Plan:
$3000 Family deductible

A non-embedded deductible means that any one person in the family could meet the entire family deductible. The HSA has a $3,000 family deductible that can be satisfied by a single person, or the combination of everyone in the family totaling $3,000. Just like the HSA deductible, the HSA out-of-pocket maximum is also non-embedded.



Choosing Between the HSA and PPO Plans

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

When choosing your plan for 2020, you need to consider the amount of money that you pay in monthly premium, the plan design and what works for your family.

A side-by-side comparison of the plans:

	HSA	PPO
Medical Out-of-Pocket Maximum	Combined Medical & Pharmacy Out-of-Pocket Max for the HSA 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: $500 Family: $1,000	N/A
Annulaized difference in the premium between the HSA and PPO Options	Employee Only will pay $600 LESS in premium on the HSA Family will pay $1,560 LESS in premium on the HSA	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?

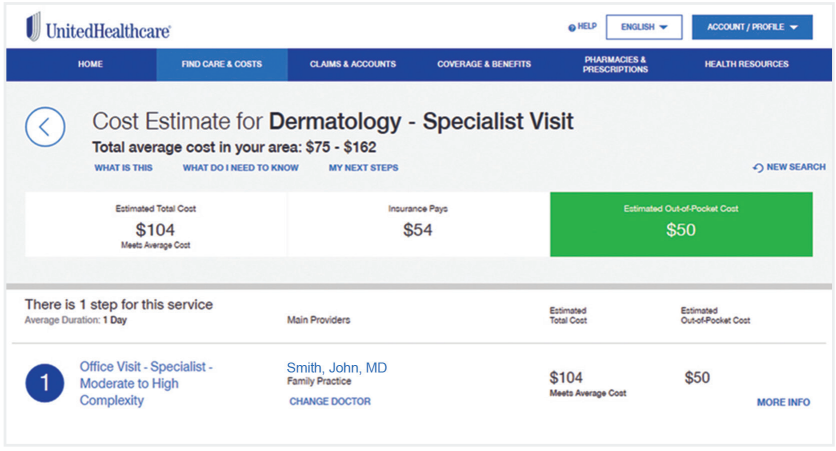
When you're deciding where to go for care, take a look at cost, as well as quality and convenience. Often you can get the care you need — and save money at the same time. Just go to **myuhc.com** to:

Find and compare costs.

Compare costs for 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.

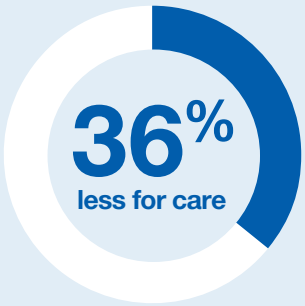
Get personalized estimates.

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



Did you know?

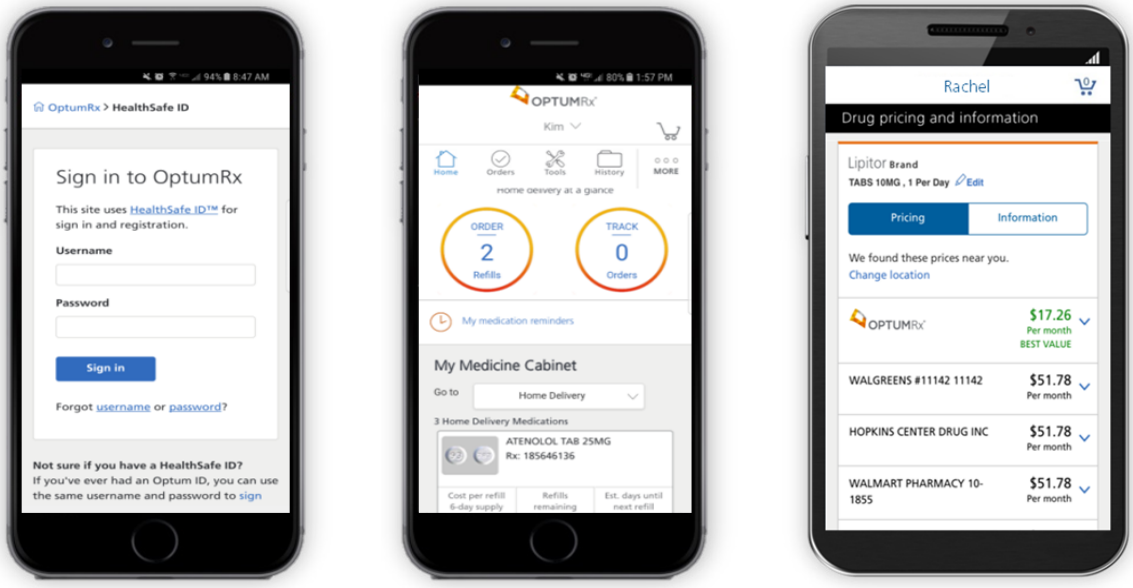
You could pay an average of 36 percent less[2] for care by checking your costs on myuhc.com.



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

How can I find out the cost of my medications?

Use the **OptumRx App** to research the cost of your prescriptions, order refills, locate a pharmacy and more! The cost estimator for the full price of your pharmacy prescriptions will be available January 1, 2020 if you choose the HSA plan.



Key features of the **OptumRx 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.

Log onto the Optum Rx app after January 1, 2020, of your prescriptions to determine the true cost 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. You can go to their website to get the list of what medications are available for free or for a very low cost. Check back as they change their drug selections.

Health4Me® 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 Health4Me® 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 Health4Me mobile app, access your benefits and coverage information, manage your accounts, and more:

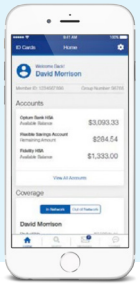
- Get health care cost estimates for specific treatments and procedures
- Review hospital quality and safety data
- Receive real-time status on account balances, deductibles and out-of-pocket spending
- Find physicians and facilities nearby
- Track and manage claims
- Pay providers
- Access your ID card

Don't delay. Know more today.

You can download the free Health4Me app through the Apple® App Store℠ or Google Play™ store for Android™ devices.

Get on-the-go access:

Health4Me 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.



Virtual Visits: Access to care online at any time

When you don't feel well, or your child is sick, the last thing you want to do is leave the comfort of home to sit in a waiting room. Now, you don't have to.

Use virtual visits when:

- Your doctor is not available
- You become ill while traveling
- You are considering visiting a hospital emergency room for a non-emergency health condition

Not good for:

- Anything requiring an exam or test
- Complex or chronic conditions
- Injuries requiring bandaging or sprains/ broken bones

A virtual visit lets you see and talk to a doctor from your mobile device or computer without an appointment.

Most visits take about 10-15 minutes and doctors can write a prescription*, if needed, that you can pick up at your local pharmacy. And, it's part of your health benefits.

You have access to a network of Virtual Visit provider groups. To learn more about Virtual Visits and our network please log into **myuhc.com®** or the UnitedHealthcare **Health4Me®** app. The Virtual Visit providers are **Doctor On Demand®**, **Amwell™** and **Teladoc®.**

You can access additional services virtually, including mental health and lactation support. Please note these services have a fee associated with them.

Once you choose a Virtual Visit provider group you'll be directed to their website from myuhc.com or their app from Health4Me. You also have the option of going directly to their website or app to access care. You can download their app directly from Google Play™ or the Apple® App Store®.

Check. Choose. Go.

When you need care, call your primary care physician or family doctor first.

Your physician has easy access to your records, knows the bigger picture of your health and may even offer same-day appointments to meet your needs. When seeing your physician is not possible, however, it's important to know your quick care options to find the place that's right for you and help avoid financial surprises. Compare your choices today at uhc.com/checkchoosego.

Quick Care Options	Needs or Symptoms		Average Cost*
24/7 Nurse Line Call the number on your health plan ID card for expert advice.	• Choosing where to get medical care • Finding a doctor or hospital	• Health and wellness help • Answers to questions about medicines	$0
Virtual Visits Anywhere, anytime online doctor visits. Virtual visit physicians can write a prescription if needed.	• Cold • Flu • Fever	• Pinkeye • Sinus problems	$
Convenience Care Clinic Treatment that's nearby.	• Skin rash • Flu shot	• Minor injuries • Earache	$$
Urgent Care Center Quicker after-hours care.	• Low back pain • Respiratory (cough, pneumonia, asthma) • Stomach (pain, vomiting, diarrhea)	• Infections (skin, eye, ear/nose/throat, genital-urinary) • Minor injuries (burns, stitches, sprains, small fractures)	$$$
Emergency Room (ER) For serious immediate needs.	• Chest pain • Shortness of breath • Severe asthma attack	• Major burns • Severe injuries • Kidney stones	$$$$

Freestanding ERs

Many people have been surprised by their bill after visiting a freestanding emergency room (FSER). FSERs, sometimes referred to as urgency centers, bill at ER rates (or higher) and can be $1,500 more than an Urgent Care Center. Neither located in nor attached to a hospital, FSERs are able to treat similar conditions as an ER but do not have an ER's ability to admit patients.

Ask before you enter:

- Is this an urgent care center or an ER?
- Is this facility a network provider?

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. See if you can determine in the following scenarios whether the care received would be considered preventive or non-preventive.

Situation 1

A woman visits her primary doctor who examines her for evidence of skin cancer as part of her preventive exam.

Answer: This is considered preventive care because her visit is part of a routine annual exam and has not been prompted by any sort of previous diagnosis.

Situation 2

A woman makes quarterly visits to the doctor for blood tests to check her cholesterol level and to confirm the medication dosage level is appropriate.

Answer: The quarterly blood tests are considered non-preventive because they are treatment for an existing condition.

At www.uhcpreventivecare.com you can find your age and gender-specific preventive care recommendations. You can download, email 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.uhcpreventivecare.com.**

Special Open Enrollment Things to Remember

- IAFF will have a **Special Open Enrollment** period in 2019 adding the HDHP with an HSA with an effective date of 1/1/20.
- The **Special Open Enrollment** period is October 9th through November 8th 2019.
- Employees that enroll during the **Special Open Enrollment** period can only enroll in the HDHP with HSA.
- Employees that DO NOT enroll in the HDHP with HSA, will complete their **2020 Regular Open Enrollment** in February 2020.
- Employees will not be allowed to change coverage during the February **Regular Open Enrollment** period.
- Employees cannot opt out of the HDHP with HSA during February 2020 **Regular 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, 2020 will have 30 days to notify Human Resources of the requested change.
- Employees can change health care plans annually at Open Enrollment, employees are required to make an active elections to change health care plans.
- Employees that enroll in the HDHP with HSA, will need to also open a health savings account with CME.
- Employees will need to complete both an active election into the HDHP and designate annual election contribution amount for the Health Savings Account.
- Employees will contribute to the health savings account 24 times annually – first and second pay of the month.
- City of Columbus will contribute $500 in a lump sum on the first available pay in January for single coverage.
- City of Columbus will contribute $1000 in a lump sum on the first available pay in January for family coverage.
- **Enrollment change forms available through IAFF's Human Resources office and attached to the back of this booklet.**

Where do I get more information?

- Additional Information available on IAFF's Local 67 website and the Employee Benefits Website under New for 2020.

Important forms on the following pages:

NICHOLE M. BRANDON
Director

THE CITY OF
COLUMBUS
ANDREW J. GINTHER, MAYOR
DEPARTMENT OF
HUMAN RESOURCES

2020 Full-Time Employee 1st and 2nd Paycheck Contribution Deductions
Effective January 1, 2020
These contributions include Medical, Prescription Drug, Dental, and Vision

				Non-smoker contributions		Smoker contributions	
IAFF	**Single**			$72.30		$97.30	
	Family			$175.75		$200.75	
						$25/MONTH **Tobacco Surcharge: Hired On or After 1/1/19**	

Group Life insurance is provided by the City at no cost to the employee if they select single or family coverage. If healthcare is waived, Group Life Insurance is available with a post-tax contribution.

NICHOLE M. BRANDON
Director

THE CITY OF
COLUMBUS
ANDREW J. GINTHER, MAYOR

DEPARTMENT OF
HUMAN RESOURCES

CITY OF COLUMBUS
COMPENSATION REDUCTION AGREEMENT
FOR GROUP BENEFIT PROGRAM

This section to be completed by the employee. Please type or print legibly (illegible forms will be returned)

Employee Name: _____SSN: _____
Date of Hire: _____
Job Class: _____
Bargaining Unit: _____
Department: _____
Division: _____

Purpose of the form:

Section 125 is part of the IRS Code that allows employees to convert a taxable cash benefit (salary) into non-taxable benefits. Under a Section 125 program you may choose to pay for qualified benefit premiums before any taxes are deducted from your paychecks. This form allows you to select the "pre-tax" option for the allowable benefits.

Items you need to understand and agree to:

- You have been provided material on the City's Health Benefit program, (defined as Medical, Prescription Drug, Dental, Vision, and Group life) and hereby certify that you have reviewed and understand the information.
- You have reviewed the personal information and coverage levels for yourself and your dependents (if any), and hereby certify the accuracy. You declare that any dependent for whom you are requesting Medical, Prescription Drug, Dental, and Vision coverage meets the definition and eligibility requirements. You understand and agree that false certification may result in disciplinary action.
- You understand that contributions from your paycheck will be made on the 1st and 2nd paychecks of the month – twenty four (24) times annually, although the City issues paychecks twenty six (26) times annually.
- You understand payroll deductions under this Agreement will continue for each pay period until this Agreement is revoked, amended or otherwise terminated.
- You understand that your compensation reported for tax purposes will be reduced in an amount equal to the rate of contribution for Group Health Program as set by the City's Benefits Wellness Programs or collective bargaining agreement.
- You understand if you have self-identified as a smoker, you will be charged an extra $25 the 1st paycheck of the month for the Group Health Program. If you successfully complete the tobacco cessation program (or the reasonable alternative) the surcharge will be removed from your contributions the first of the month after Human Resources and Payroll have been notified.
- You understand that the reduction amount will be automatically adjusted in the event of a change in the contribution rate and that your elections are irrevocable unless you experience a qualifying life event change. Human Resources must receive notification of such change within 30 days.
- You understand the value of the City's Group Health Program coverage for a domestic partner and their dependent children (if any) is considered post-tax contribution on the 1st and 2nd paychecks of the month and that the value of the healthcare cost is imputed income and will be included as taxable wages on form W-2.

NICHOLE M. BRANDON
Director

THE CITY OF
COLUMBUS
ANDREW J. GINTHER, MAYOR

DEPARTMENT OF
HUMAN RESOURCES

Selections you need to make. Choose only one.

Pre-tax option for HDHP with HSA ONLY

☐ I elect the Medical, Prescription Drug, Dental, Vision and Basic life programs. I understand and have read all of the rules under the Section 125 IRC provisions listed above. I elect to participate in the full High Deductible Health Plan with Health Savings Account benefit package for my employment class. By checking this box, I understand that **my future salary will be reduced to pay for my premiums on a pre-tax basis** for the Medical, Prescription Drugs, Dental, Vision coverages. Under this option the City pays for my Group Life coverage.

☐ **Pre-tax option for full benefit package – *High Deductible Health Plan with Health Savings Account.*** Please indicate your annual contribution amount to the health savings account with minimum increments of $20.00 per month, or up to the annual maximum set by the IRS.

(*For Plan Year 2020 - Single $295.83 per month or Family $591.67 per month maximums*)

Pre-tax option for HDHP benefit package – *Health Savings Account contribution election.*

$_____ 1st and 2nd Paycheck Contributions amount to a Health Savings Account

$_____ Total Annual Contribution (line above X 12)

Waive all coverages except Group Life Insurance

☐ I elect to waive the Medical, Prescription Drug, Dental, and Vision programs but elect to have my Group Life insurance. I understand I will pay $5.50 per month on a post-tax basis to have the Group Life insurance.

Waive all coverages

☐ I do not want to participate in any of the Group Benefit Programs. By checking this box, I understand I will not be enrolled and will not have any contributions deducted from my paycheck.

Signature: _____ Date: _____

**Please complete the enrollment change form with dependent information and your smoking surcharge status form.*

Enrollment Application/Change/Cancellation Request

Ohio

UnitedHealthcare®

Coverage Provided by "UnitedHealthcare and Affiliates":
Medical coverage provided by ☐ UnitedHealthcare Insurance Company, ☐ UnitedHealthcare Life Insurance Company or ☐ UnitedHealthcare of Ohio, Inc.
Dental coverage provided by ☐ UnitedHealthcare Insurance Company or ☐ UnitedHealthcare of Ohio, Inc.
Life Insurance coverage provided by ☐ UnitedHealthcare Insurance Company
Vision coverage provided by ☐ UnitedHealthcare Insurance Company

☐ **Enroll**
☐ **Cancel**
☐ **Change**

☐ **HSA**
☐ **Traditional PPO**

☐ **Address Change**
☐ **Name Change**
Date of Change____ /___ /____

To Be Completed By Employer

ATTENTION EMPLOYER REPRESENTATIVE: To ensure accurate processing of application, 1) please review all sections and confirm the employee completed the appropriate information, 2) complete the information in this section and 3) provide your signature and today's date. If the employee is waiving coverage, do not submit the application but retain it for your records.

Company Name	Group #	Department #

Plan Variation	**Reporting Code**	**Benefit Level/Class Code, if applicable**
Medical _____ Vision _____	Medical _____ Vision _____	Life/AD&D _____ Suppl. Life _____
Dental _____ Life _____	Dental _____ Life _____	Spouse Life _____ Suppl. AD&D _____

☐ **New Enrollment/Additions: (Check one)**
Date of Hire ___ /___ /___ Requested Date of Coverage ___ /___ /___
☐ New Hire ☐ Status Change (PT to FT)
☐ Return from Leave/Layoff
☐ Birth ☐ Marriage ☐ Adoption
☐ Court ordered dependent
☐ Other (describe) _____
☐ COBRA/State Continuation start date _____ stop date_____
☐ **Annual Open Enrollment** Requested Effective Date of Enrollment ___ /__ /___

☐ **Cancellations:** Last Date of Employment ___ /___ /___
Requested Effective Date of Cancellation ___ /___ /___
☐ Cancel all coverage
☐ Cancel all listed below – Section B
Reason: (check one)
☐ Death ☐ Employee Terminated ☐ Divorce
☐ Moved out of service area
☐ Dependent reached dependent max age
☐ Other (describe)_____

Employee Type ☐ Union ☐ Non-union	☐ Salaried ☐ Hourly	☐ Active ☐ COBRA/State Cont. ☐ Retire Date _____	#Hours worked per week _____

Signature _____ Date _____

Employer Position_____ Phone Number_____

A. Employee Information

Last Name	First Name	MI	Social Security Number
			___ – ___ – ____

Address	Apt #	City	State	Zip Code	Home/Cell Phone

Date of Birth / /	Sex ☐ M ☐ F	Marital Status ☐ Single ☐ Divorced ☐ Married ☐ Widowed	Work Phone

Email Address

Language Preference, if not English

Race – Check all that apply (Optional) [2]
☐ American Indian/Alaska Native ☐ Asian ☐ Black/African-American
☐ Hispanic/Latino ☐ Native Hawaiian/Pacific Islander ☐ White
☐ Other–Please specify _____

Primary Physician [1]
Physician First & Last Name _____
ID # ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ - ___ ___ ___ ___

Primary Dentist [1]
Dentist First & Last Name _____
ID# _____

[1]IMPORTANT: Please see employer representative as some plans require a Primary Physician (Primary Care) and/or a Primary Care Dentist (PCD) selection.

[2]Data collected will be used only to help communicate with enrollees and inform them of specific programs to enhance their well-being and not for eligibility or claim payment determination.

B. Family Information

List All Enrolling/Changing/Cancelling (Attach sheet if necessary)

Check appropriate box	Relationship[2]	Last Name	First Name	MI	Sex	Date of Birth
☐ Enroll ☐ Cancel ☐ Change	Spouse /Domestic Partner				☐ M ☐ F	_____ /_____ /_______
		Social Security Number ___ ___ ___ – ___ ___ – ___ ___ ___ ___		Primary Physician[1] Name: ID# ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ - ___ ___ ___ ___		
Race – Check all that apply (Optional)[3]	☐ American Indian/Alaska Native ☐ Asian ☐ Black/African-American ☐ Hispanic/Latino ☐ Native Hawaiian/Pacific Islander ☐ White ☐ Other–Please specify ______________			Primary Care Dentist[1] Name: ID#		

Check appropriate box	Relationship[2]	Last Name	First Name	MI	Sex	Date of Birth
☐ Enroll ☐ Cancel ☐ Change	Dependent				☐ M ☐ F	_____ /_____ /_______
		Social Security Number ___ ___ ___ – ___ ___ – ___ ___ ___ ___		Primary Physician[1] Name: ID# ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ - ___ ___ ___ ___		
Race – Check all that apply (Optional)[3]	☐ American Indian/Alaska Native ☐ Asian ☐ Black/African-American ☐ Hispanic/Latino ☐ Native Hawaiian/Pacific Islander ☐ White ☐ Other–Please specify ______________			Primary Care Dentist[1] Name: ID#		

Check appropriate box	Relationship[2]	Last Name	First Name	MI	Sex	Date of Birth
☐ Enroll ☐ Cancel ☐ Change	Dependent				☐ M ☐ F	_____ /_____ /_______
		Social Security Number ___ ___ ___ – ___ ___ – ___ ___ ___ ___		Primary Physician[1] Name: ID# ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ - ___ ___ ___ ___		
Race – Check all that apply (Optional)[3]	☐ American Indian/Alaska Native ☐ Asian ☐ Black/African-American ☐ Hispanic/Latino ☐ Native Hawaiian/Pacific Islander ☐ White ☐ Other–Please specify ______________			Primary Care Dentist[1] Name: ID#		

Check appropriate box	Relationship[2]	Last Name	First Name	MI	Sex	Date of Birth
☐ Enroll ☐ Cancel ☐ Change	Dependent				☐ M ☐ F	_____ /_____ /_______
		Social Security Number ___ ___ ___ – ___ ___ – ___ ___ ___ ___		Primary Physician[1] Name: ID# ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ - ___ ___ ___ ___		
Race – Check all that apply (Optional)[3]	☐ American Indian/Alaska Native ☐ Asian ☐ Black/African-American ☐ Hispanic/Latino ☐ Native Hawaiian/Pacific Islander ☐ White ☐ Other–Please specify ______________			Primary Care Dentist[1] Name: ID#		

[1] IMPORTANT: Please see employer representative as some plans require a Primary Physician (Primary Care) and/or a Primary Care Dentist (PCD) selection.

[2] For some cases, such as Qualified Medical Child Support, additional documentation may be required. Please see employer representative for more information.

[3] Data collected will be used only to help communicate with enrollees and inform them of specific programs to enhance their well-being and not for eligibility or claim payment determination.

C. Product Selection

Please check the box for each coverage in which you or your dependents are enrolling.
If your employer offers a choice of plans, indicate which plan you are selecting. Indicate the dollar amount selected for the Life and Accidental Death & Dismemberment (AD&D), Supplemental Life, Short-Term Disability (STD), and Long-Term Disability (LTD) plans. Benefit offerings are dependent upon employer selection.

Person	Medical	Dental	Vision	Basic Life/AD&D	Supp Life/AD&D	Voluntary AD&D
Employee	☐ ________	☐ ________	☐	☐ $________	☐ $________	☐ $________
Spouse [Domestic Partner]	☐	☐	☐	☐ $________	☐ $________	☐ $________
Dependent	☐	☐	☐	☐ $________	☐ $________	☐ $________

Person	STD	LTD	STD Buy Up	LTD Buy Up	Salary $ _________ Required only if
Employee	☐	☐	☐	☐	Life, STD, or LTD based on salary

Life Insurance Beneficiary Full Name and Address (if applying for Life Insurance with UnitedHealthcare)		Relationship
Primary		
Secondary		

D. Other Medical Coverage Information

This section must be completed. (Attach sheet if necessary.)

On the day this coverage begins, will you, your spouse or any of your dependents be covered under any other medical health plan or policy, including another UnitedHealthcare plan or Medicare? ☐ YES (continue completing this section) ☐ NO (skip the rest of this section)

Name of other carrier _____

Other Group Medical Coverage Information (only list those covered by other plan)	Type (B/S/F)*	Effective Date	End Date	Name and date of birth of policyholder for other coverage
Spouse Name:				
Dependent Name:				
Dependent Name:				
Dependent Name:				

*B. Enter 'B' when this dependent is covered under both you and your spouse's insurance plan (married)

S. Enter 'S' if you are the parent awarded custody of this dependent and no other individual is required to pay for this dependent's medical expenses.

F. Enter 'F' if this dependent is covered by another individual (not a member of your household) required to pay for this dependent's medical expenses.

Medicare – Employee Information: If enrolled in Medicare, please attach a copy of your Medicare ID card.

☐ Enrolled in Part A: Effective Date _____ ☐ Ineligible for Part A* ☐ Not Enrolled in Part A (chose not to enroll)

☐ Enrolled in Part B: Effective Date _____ ☐ Ineligible for Part B* ☐ Not Enrolled in Part B (chose not to enroll)

☐ Enrolled in Part D: Effective Date _____ ☐ Ineligible for Part D* ☐ Not Enrolled in Part D (chose not to enroll)

Reason for Medicare eligibility: ☐ Over 65 ☐ Kidney Disease ☐ Disabled ☐ Disabled but actively at work

Medicare – Spouse/Dependent Name: _____

☐ Enrolled in Part A: Effective Date _____ ☐ Ineligible for Part A* ☐ Not Enrolled in Part A (chose not to enroll)

☐ Enrolled in Part B: Effective Date _____ ☐ Ineligible for Part B* ☐ Not Enrolled in Part B (chose not to enroll)

☐ Enrolled in Part D: Effective Date _____ ☐ Ineligible for Part D* ☐ Not Enrolled in Part D (chose not to enroll)

Reason for Medicare eligibility: ☐ Over 65 ☐ Kidney Disease ☐ Disabled ☐ Disabled but actively at work

*Only check "Ineligible" if you have received documentation from your Social Security benefits that indicate that you are not eligible for Medicare.

E. Waiver of Coverage

I decline coverage for:
- ☐ Myself
- ☐ Spouse
- ☐ Dependent Children
- ☐ Myself and all dependents

Declining coverage due to existence of other coverage:
- ☐ Spouse's Employer's Plan
- ☐ Individual Plan
- ☐ Covered by Medicare
- ☐ Medicaid
- ☐ COBRA from Prior Employer
- ☐ VA Eligibility
- ☐ Tri-Care
- ☐ I (we) have no other coverage at this time
- ☐ Other _____

I understand that by waiving coverage at this time, I will not be allowed to participate unless I qualify at a special enrollment period or as a late enrollee, if applicable, or at the next open enrollment period. I acknowledge that I have received the "Important Information" statement which is included with this form.

Employee Initials	Date

F. Signature

Your enrollment in the plan is expressly conditioned upon your acceptance of all terms and conditions contained in this enrollment application. If you do not agree to the following terms and conditions, you may not complete your enrollment.

TERMS AND CONDITIONS

As a condition of my and/or my dependents' participation in the plan, and in consideration for the privileges that come from participation in the plan, I hereby agree for myself and/or for my dependents as follows:

I recognize and understand that the plan contracts with physicians and other providers that make up the plan network. I recognize that all physicians and other providers that participate in the plan network are subject to credentialing under applicable State regulations and pursuant to the plan's network credentialing process. I understand that such credentialing includes a review of provider education, training and licensure. However, by participating in the plan I hereby acknowledge and accept that the plan is not a provider of medical services, and I am aware that obtaining or not obtaining medical care involves significant risks such as serious injury and even death. I acknowledge that the credentialing of physicians and other providers does not in any way reduce this risk. I agree to assume all risks and responsibility for, and hold the plan harmless from, any and all claims for damages, including personal injury or death, medical expenses, disability, lost wages, and loss of earning capacity which may be incurred or associated with medical treatment obtained through a participating physician or other provider. I recognize that all physicians and other providers that participate in the plan network are independent contractors and not the plan's employees or agents and are solely responsible for any malpractice, adverse outcomes, or any other claims arising from medical treatment rendered to me and my dependents. I HEREBY AGREE THAT THE PLAN IS NOT RESPONSIBLE NOR LIABLE FOR ANY ADVICE, COURSE OF TREATMENT, DIAGNOSIS OR ANY OTHER INFORMATION, SERVICES OR PRODUCTS THAT I OR MY DEPENDENTS OBTAIN THROUGH A PARTICIPATING NETWORK PHYSICIAN OR OTHER PROVIDER.

(continued on next page)

F. Signature (Continued)

I recognize and understand that the plan does not recommend, endorse or make any representation about the appropriateness or suitability of any specific tests, products, procedures, treatments, services, or opinions. I recognize that the plan, plan documents, and any health and wellness information provided by the plan, are not intended or implied to be a substitute for professional medical advice, diagnosis or treatment. I agree to confirm any medical information obtained from or through the plan with other sources, and will review all information regarding any medical condition or treatment with my physician. I HEREBY AGREE TO NEVER DISREGARD PROFESSIONAL MEDICAL ADVICE OR DELAY SEEKING MEDICAL TREATMENT BECAUSE OF SOMETHING I HAVE READ OR ACCESSED THROUGH THE PLAN.

I confirm that the information I have provided on this form is complete and accurate.

I understand that the health benefit plan that I have selected provides reimbursement for certain medical costs, which are more fully described in the current Certificate of Coverage. I understand there may be instances where treatment decisions made by my physician or me or medical expenses which I have incurred may not be covered by my health benefit plan.

I understand that information collected in connection with administration of the benefit plan may be used to bring to my attention health products or services that might be valuable to me and otherwise as permitted by law. I understand that you may combine that information with other information so that it is no longer individually identifiable and use it for commercial and other purposes.

I acknowledge that I have received the "Important Information" statement which is included at the end of this form.

Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

Date	Employee Signature for all applying and waiving	Spouse Signature (if applying for coverage)

IMPORTANT INFORMATION

In order to make choices about your health care coverage and treatment, we believe that it is important for you to understand how your plan operates and how it may affect you. In an ever-changing environment, the information can never be complete and we urge you to contact us if, after enrollment, your Certificate of Coverage or other materials do not answer your questions. Further information is available at **www.myuhc.com** or at the toll-free Customer Care number located on the back of your identification card or on other plan materials.

1. We do not provide health care services or make treatment decisions. We help finance and/or administer the health benefit plan in which you are enrolled. That means:
   - We make decisions about whether the health benefit plan you chose will reimburse you for care that you may receive.
   - We do not decide what care you need or will receive. You and your provider make those decisions.
2. We may enter into arrangements where another entity carries out some of our duties, but those entities must operate consistently with our commitment to your plan.
3. We may use individually identifiable information about you to identify for you (and you alone) procedures, products, and services that you may find valuable.
4. We contract with networks of physicians and other providers. Our credentialing process confirms public information about the providers' licenses and other credentials, but does not assure the quality of the services provided.
5. Physicians and other providers in our networks are independent contractors and are not our employees or agents. We do not control nor do we have a right to control your provider's treatment or plan.
6. We may enter into agreements with your physician or other provider to share in the cost savings that our approach may generate. We encourage providers in our network to disclose the nature of those arrangements with you. If they do not, we encourage you to talk to your provider about these arrangements.
7. We encourage physicians and other providers to talk with you about care you or your provider think might be valuable.
8. We will use individually identifiable information about you as permitted by law, including in our operations and in our research. We will use anonymous data for commercial purposes including research.

Statement of affirmation and authorization to obtain and disclose information in connection with eligibility for coverage.

I (we) request the indicated group coverage for myself and, if the plan provides, for my dependents. I authorize any required premium contributions to be deducted from earnings.

I (we) authorize all providers of health services or supplies and any of their representatives to give the following to the HMO/insurance company(ies): any available information about the health history, condition, or treatment of any persons named in this request. I (we) authorize the HMO/insurance company(ies) to use this information to determine eligibility for health coverage and eligibility for benefits under an existing policy.

I (we) also authorize the HMO/insurance company(ies) to give this information to its (their) representatives or to any other organization for the reason notified above. I (we) agree that this authorization is valid for 30 months from the date below. I (we) know that I (we) have the right to ask for and to receive a copy of this authorization.

I understand that the Certificate of Coverage and other documents, notices, and communications regarding my health benefit plan may be transmitted electronically.

I (we) have not given the agent or any other persons any health information not included on the Request for Coverage. I (we) understand that the HMO/insurance company(ies) is not bound by any statements I (we) have made to any agent or to any other persons, if those statements are not written or printed on this Request for Coverage and any attachments.

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

- Go to the website: **www.cmefcu.org**
- Click on "Open An Account"
- Click on "Open An Account"/blue box (again)
- Click on "Personal" Account
- **Eligibility**: "I qualify for membership because....." Click in the box for "I live/work/worship or attend school in an eligible county". Use the drop down boxes to select your county & select "City of Columbus Division of Fire." Click on 'continue'.
- Read "Disclosure" & scroll to bottom, click the small box next to... "I have read...." And hit "continue".
- **Default Products**: Choose your first account. (The HSA will be a 'sub-account'....you must select the **Advantage Share** in order to move forward.) Click the blue box that says "Select" for the Advantage Share. A box will pop up and click on "Add Account", then "Continue". In the box that pops up, be sure **e-statements is marked with a checkmark** and "Add Account" (Please note: You will not be actually sending CMEFCU $5 for the membership, the credit union will take care of that for you!)
- Click "Continue"
- **Available Products**. Click on the HSA tab on the left hand side of the screen, a box will pop up and click on the blue " + " sign. Another box will pop up. Find where "Optional features" is, Click in the box that says "HSA Debit Card," so that one is ordered for you. Scroll down to where it says "Additional Info" – answer the questions in the drop down boxes. **Family** or **Individual** and **Married** or **Unmarried**. Click on "Add Account".
- Next you will see **Review Products**. Be sure you have two listed: **Advantage Share** and the **HSA**. Click "continue."
- **Applicant Information**: Proceed in filling out all this necessary information.
  - "**Phone**" – When you get to this field, be sure to add your cell phone number under "Home" phone, if you don't have a land line phone at home.
  - **"Employer"** – When you get to this field, be sure to mark at least 1 month duration, if you are a new employee.
  - When you get to the bottom and see "Additional Info" And it asks, how did you hear about CMEFCU – please select "Health Savings Account" That's just so the credit union can track where the account came from.
- Next you will see **Accounts** – please select a **username** and **password**.
- Next is **Beneficiary** – if something should happen to you and you have a balance in your account whom will be the beneficiary to those funds? You don't have to have one listed, however, it is recommended. Their first and last name and birthday are required to name a beneficiary.
- **Account Funding** – In order to get through this screen, please use the drop down for Advantage Share and type in **$5**. Then mark "Mail a check or money order" – But DON'T send a check or money order. And then mark the box "I agree..." & continue.
- **Review Application** – This is a snapshot of everything you filled out. If it looks correct, then mark the box at the very bottom that says: "By clicking the I agree..." and hit **Submit**.

The next page you'll see are four questions. These four questions are to verify your identity since you just went online and filled out an application. Answer these, the best you can. If the answer is not in the drop down box, just mark "doesn't apply".

Once those are answered,
you have completed the application for the Health Savings Account.

Next this application will be processed and you will receive an email from 'DocuSign/CME' – this is how we capture your electronic signature. Once that is done, we'll order a debit card(s). Those will arrive in a plain white envelope in about 10-14 business days.

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

- Go to the website: **www.cmefcu.org**
- Look for the dark blue **MEMBER LOGIN** box & click on that.
- Type in your **User Name** & click on Sign In
- Next, type in your **password**
- You will need a **passcode** to go forward. So use the drop down and choose which method works best for you.
- Type in the passcode that's sent. And then you should be looking at your **Account Summary** page.
- There are tabs highlighted on a blue colored bar...click on **Application Center**
- On this screen, click on **+Start New Application**
- At the top of the page look for "Click here to add additional deposit products to your current account" Click on the word "add"
- **Available Products Page.** Click on the HSA tab on the left hand side of the screen, a box will pop up and click on the blue " **+** " sign.
  - Another box will pop up. Find where "Optional features" is, Click in the box that says "HSA Debit Card," so that one will be ordered for you.
  - Scroll down to where it says "Additional Info" – answer those questions in the drop down boxes. **Family or Individual** and **Married or Unmarried**. And click on "Add Account".
- Click the blue "Continue" box at the bottom of the page.
- Confirm your personal information is correct.
- Click the blue "Continue" box at the bottom of the page.
- Add a **Beneficiary** if you want to and click "Continue"
- Leave the Deposit field at **$0.00** and click "Continue"
- Review your personal information and click "Submit"
- Answer your identifying information.

Once those are answered,
you have completed the application for the Health Savings Account.

Next this application will be processed and you will receive an email from 'DocuSign/CME' – this is how we capture your electronic signature. Once that is done, we'll order a debit card(s). Those will arrive in a plain white envelope in about 10-14 business days.

Having trouble completing the online application to open your HSA?

*If there is something you don't understand or are not sure of, please email or call **Sallie Cerrie**, CME Federal Credit Union's Member Relations Officer, and she'll be happy to help!*

scerrie@cmefcu.org • 614-396-4570

Tobacco Surcharge
Frequently Asked Questions

1. What is the tobacco surcharge?

Starting January 1, 2018, the City of Columbus will implement a $25 per month surcharge for employees hired after January 1, 2018 who enroll in the City of Columbus Health Insurance Plan and disclose their personal use of tobacco.

2. Why is the City implementing a tobacco surcharge?

The use of tobacco can have a negative effect on the health of the user. The surcharge is being implemented to encourage users to quit the use of tobacco by enforcing a surcharge. Coupled with this is the City's Quit for Life tobacco cessation program. The goal of the surcharge is to support the health and wellness of City employees by discouraging the use of tobacco products. The City promotes a wellness culture and the use of tobacco is inconsistent with this culture.

3. What is considered a tobacco product?

The following are considered tobacco products. If you use any of these products you must certify as a tobacco-user. Tobacco products include but are not limited to: Cigarettes, cigars, cigarillos, pipes, chewing tobacco, snuff, dip, and loose tobacco smoked via pipe, hookah or hand rolled cigarettes, and electronic cigarettes and/or vaporizers if they contain tobacco.

4. I am hired on or after January 1, 2018 and the surcharge is applicable to me but I do not use any tobacco products - do I need to do anything?

Yes. When you initially enroll in the City's Health Insurance you will need to fill out the Declaration of Tobacco Usage form indicating that you are not a tobacco user. This will waive the requirement to pay the monthly surcharge. The declaration will remain in effect unless your status as a non-user changes.

5. I am hired on or after January 1, 2018 and the surcharge is applicable to me and I DO use tobacco products what do I need to do?

When you initially enroll in the City's Health Insurance you will need to fill out the Declaration of Tobacco Usage form indicating that you are a tobacco user. This will initiate the implementation of the tobacco surcharge. The declaration will remain in effect unless your status as a user changes.

6. If my status as a user changes to a non-user, what am I obligated to do?

If you successfully quit using tobacco, you are obligated to fill out a new Declaration of Tobacco Usage form at open enrollment and indicate that you are not a tobacco user. This will waive the tobacco surcharge. The declaration will remain in effect unless your status as a user changes.

In addition, if you complete the City's Quit for Life Tobacco Cessation program, or similar approved program (see FAQ 16), within six months of enrollment, the surcharge will no longer apply for that benefit year and your surcharge will be reimbursed from the beginning of the benefit year in which the program is completed.

You should only change your status to non-user if you have successfully quit tobacco. If you do successfully quit using tobacco, you are obligated to fill out a new Declaration of Tobacco Usage form at the next open enrollment and indicate that you are not a tobacco user.

Tobacco Surcharge
Frequently Asked Questions, continued

7. If my status as a non-user changes to a user, what am I obligated to do?

If your tobacco status changes, you are obligated to fill out a new Declaration of Tobacco Usage form at open enrollment and indicate that you are a tobacco user. This will initiate the implementation of the tobacco surcharge.

8. How do I avoid the Tobacco surcharge?

Currently, federal law requires the City to offer employees an alternative method of avoiding the tobacco surcharge. This alternative method is also known as a "reasonable alternative standard." The City of Columbus offers Quit for Life, a tobacco cessation program, as a reasonable alternative standard. By enrolling in the Quit for Life Program and completing five (5) sessions within six (6) months from initial enrollment in the health plan or from the first day following the open enrollment period, you will be eligible for a reimbursement of the surcharge paid in the benefit year the program is completed. In addition, the surcharge will no longer apply for that benefit year. You can enroll by calling 1-866-Quit-4-Life (1-866-784-8454) or online at www.quitnow.net. It is your responsibility to fill out a Reasonable Alternative Standard ("RAS") Completion form indicating that you completed the Quit for Life program. The form should be submitted to your department Human Resources Representative.

9. Can I enroll in the Quit for Life Tobacco Cessation program after open enrollment?

Yes, you may enroll in the Quit for Life Tobacco Cessation program at any time. However, you will only be eligible for the reimbursement of the tobacco surcharge within six (6) months from initial enrollment in the health plan or from the first day following the open enrollment period for that benefit year.

10. What if I only use tobacco products once in a while?

The Declaration of Tobacco Usage form requires you to declare as a tobacco user or that you are not a user. The frequency of usage is not a factor.

11. What if I am caught using tobacco products?

Falsification of the Declaration of Tobacco Usage form may result in disciplinary action up to and including termination.

12. How will you monitor tobacco usage status?

The Declaration of Tobacco Usage form is completed at the time of hire and enrollment in the City health insurance plan. The form remains in effect until you take action that would change your status, i.e. you successfully quit tobacco or you begin using tobacco and change your declaration at open enrollment.

13. Does this only apply to using tobacco products during my work hours?

No. The Declaration of Tobacco Usage form asks if you are a user or if you are not a user of tobacco products.

14. What will the City do with the funds collected from the tobacco surcharge?

The tobacco surcharge will be deposited in the Employee Benefits Fund to pay health insurance claims.

Tobacco Surcharge
Frequently Asked Questions, continued

15. I am currently using the nicotine patch; does that count as tobacco use?

No.

16. What if I am already in a tobacco cessation program? Will that count if I quit tobacco use through my current cessation program?

If an employee is currently engaged in a tobacco cessation program, the City encourages the employee to follow through and complete the program. The City will accept the completion of a tobacco cessation program if it is in progress at the time of the rollout and it similar to the Quit for Life program requirements. The employee must submit medical documentation of the program's completion by an authorized medical provider to validate the employee's successful tobacco cessation program.

17. What if I quit tobacco use on my own (i.e., going cold turkey), without assistance of a tobacco cessation program?

If your tobacco status changes, you are obligated to fill out a new Declaration of Tobacco Usage form at open enrollment and indicate that you are not a tobacco user. Unlike Quit for Life, there is no reimbursement available for employees that quit on their own. The City of Columbus applauds any effort to quit tobacco use, but understands the difficulties of quitting and encourages employees to enroll in the Quit for Life Program. After completing five (5) sessions within six (6) months from initial enrollment in the health plan or from the first day following the open enrollment period, employees that complete the Quit for Life Program will be eligible for a reimbursement of the surcharge paid in the benefit year the program is completed. You can enroll by calling 1-866-Quit-4-Life (1-866-784-8454) or online at www.quitnow.net.

City of Columbus
90 West Broad Street
Columbus, Ohio 43215

Declaration of Tobacco Usage

Employee Name: _____

Date of Hire: _____

Job Class: _____

Bargaining Unit: _____

Department: _____

Division: _____

In consideration of my enrollment in the City of Columbus Health Insurance Plan, I certify that:

☐ **I am Tobacco Free**: I do not smoke, vape or use any form of tobacco in any amount. _____ (initials)

☐ **I am a Tobacco User**: I smoke, vape or use other forms of tobacco._____ (initials)

I acknowledge that my self-identification as a tobacco user will result in a $25 per month surcharge added to my employee health insurance premium contribution.

I further declare that the above statement is true and complete and agree that it forms part of the application process for health insurance with the City of Columbus.

I understand that knowingly providing false or misleading information in this Declaration may result in any or all of the following actions by the City of Columbus:

1) Disciplinary action, up to and including termination
2) Civil and/or criminal prosecution

The City and your health plan are committed to helping you achieve your best health.

You can avoid the tobacco use premium surcharge by enrolling in the Quit for Life program and by completing five (5) sessions within six (6) months of initial enrollment in the health plan or from the first (1) day of open enrollment, annually thereafter. You can enroll in Quit for Life by calling **1-866-QUIT-4-LIFE (1-866-784-8454)** or online at **www.quitnow.net**.

Questions about the tobacco cessation program should be directed to a Healthy Columbus Representative at (614) 645-3892. The Quit for Life program is open to all City employees and any adult dependent over 18 who is on the City's health plan. For questions about enrollment and completion in alternative tobacco cessation programs, please refer to the Tobacco Surcharge FAQs.

Employee Printed Name: _____

Employee Signature: _____

Date: _____

Notes

THE CITY OF
COLUMBUS
ANDREW J. GINTHER, MAYOR

DEPARTMENT OF
HUMAN RESOURCES