THE CITY OF
COLUMBUS
ANDREW J. GINTHER, MAYOR

DEPARTMENT OF
HUMAN RESOURCES

IAFF HDHP Open Enrollment 2022:

Open Enrollment is November 7th – December 4th, 2021.

Review the enclosed information to learn more about:

- HDHP Medical with HSA
- 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, your 2021 contribution election amount will not automatically rollover. An HSA is a personal bank account that YOU own, open your CME Federal Credit Union account by **December 31, 2021**.

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.

Are you tuned in to Five on Fridays and the Wellness Wednesday Newsletter?

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

United Healthcare

HDHP Account with Health Savings Accounts (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 plans and how they work.

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

No, HDHP 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 status or having dependents. HDHP plans 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 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 HDHP 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 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 or health plans, or retire.

"HDHP 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 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.

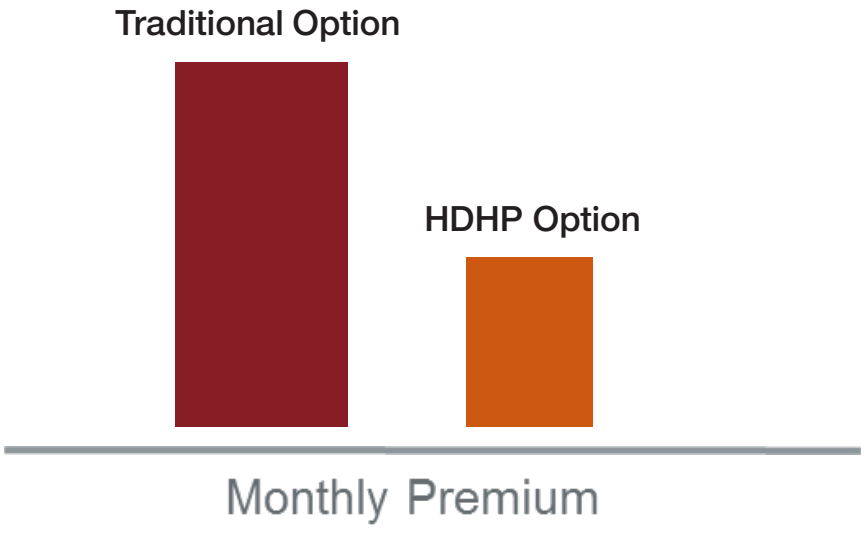
UnitedHealthcare Medical Plans

IAFF 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 November open enrollment window.

Premium Comparison

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



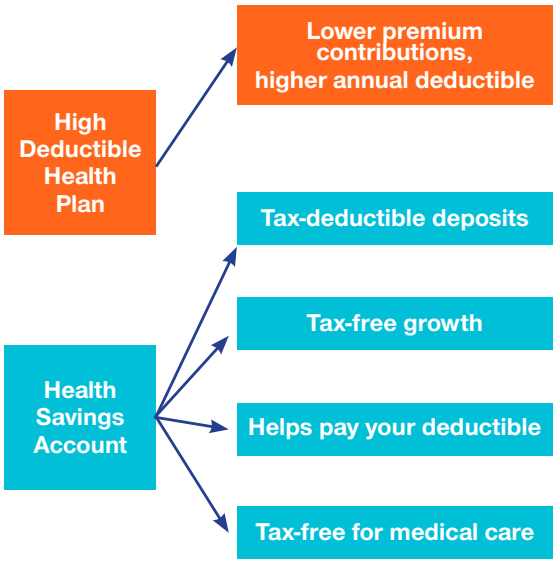
Your per pay contribution is less if you choose the HDHP, which adds up to BIG savings. Think about depositing your premium savings into your HSA Account!

Premium contribution savings between PPO & HDHP Plans

- **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)

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 bi-annually. The money is federal 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 needs – even into retirement. No "use it or lose it."

- You or others make deposits to grow the account
- Money you spend from your HSA is for qualified medical expenses
- You can earn interest on your balance, see a CME representative for more details

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 twice annually in plan year 2022. Once in January and a second deposit in July.

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

Participants in the HDHP will pay lower monthly premium contributions.

Healthcare consumers will instead deposit the premium savings money into the 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 table below shows 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 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.

*Sick Leave Reciprocity and Fitness Incentive elections, if applicable can also be used to fund the HSA. Your sick leave reciprocity and/or fitness incentive can be direct deposited into your CME HSA bank account allowing IAFF participants to maximize their tax advantaged account.

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Health Savings Bank Account

What are the 2022 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 2022, single coverage can contribute up to $3,650 per year and family coverage can contribute up to $7,300 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 2022

- $600 for Single Coverage
- $1,200 for Family Coverage
- Sick leave reciprocity and/or Fitness Incentive

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 and enter your annual HSA contribution amount after you elect the HDHP for plan year 2022. 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 IAFF members who took the HSA option in both 2020 & 2021.)

e-Contribute

Contact CME to set up an electronic transfer from an existing 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 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 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 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

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, 2022 account funding is available in January
- 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 available, 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 46** has complete instructions for how **new** CME Federal Credit Union Members can open an HSA Bank Account.*

***Page 47** has instructions for **existing** CME members.*

2022 Open Enrollment:
Comparison of In-Network Plan Designs

	Traditional PPO In-Network only	HDHP w/HSA In-Network only
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 (OOPM)		
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 myUHC.com for drug cost resources after January 1, 2022)

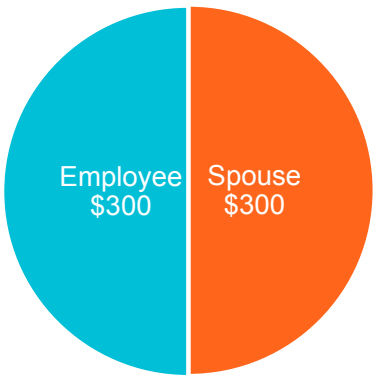
Please note these are in-network benefits; just like today, both plans have a separate, higher expense out-of-network schedule of benefits to you.

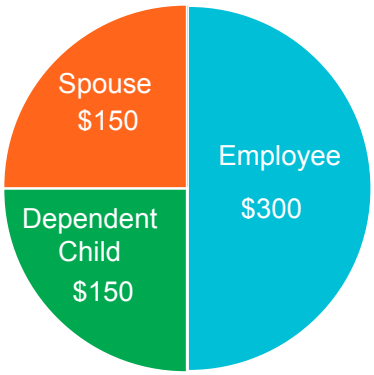
Embedded vs Non-Embedded Deductible

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.

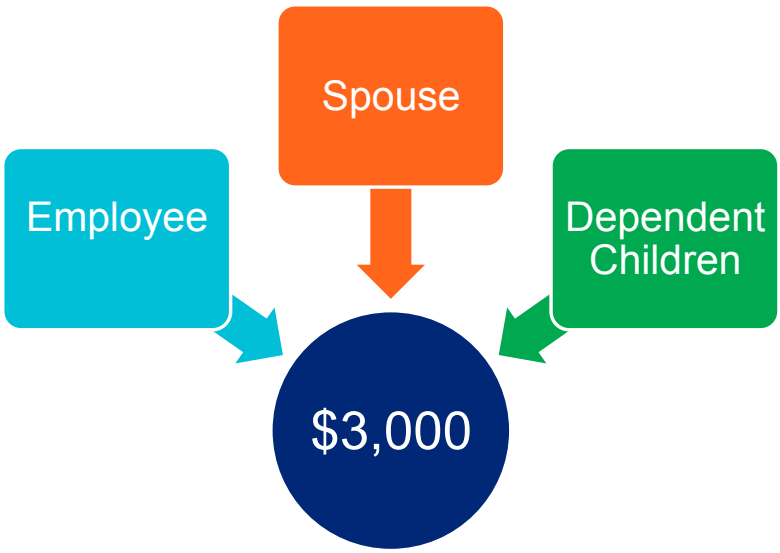




What does "Non-Embedded" deductible mean?

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 HDHP 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 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 2022, 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:

	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?

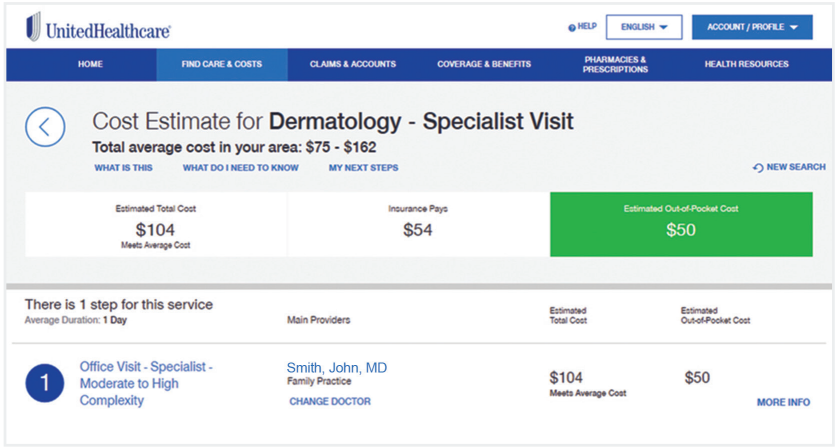
When you're deciding where to go for care, take a look at cost, as well as quality and convenience. Often you can get the care you need — and save money at the same time. Just go to ***myuhc.com*** *to:*

Find and compare costs.

Compare costs for 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.

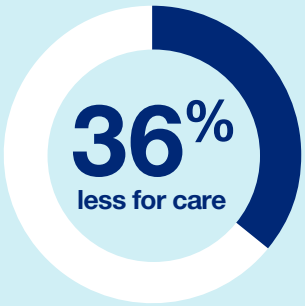
Get personalized estimates.

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



Did you know?

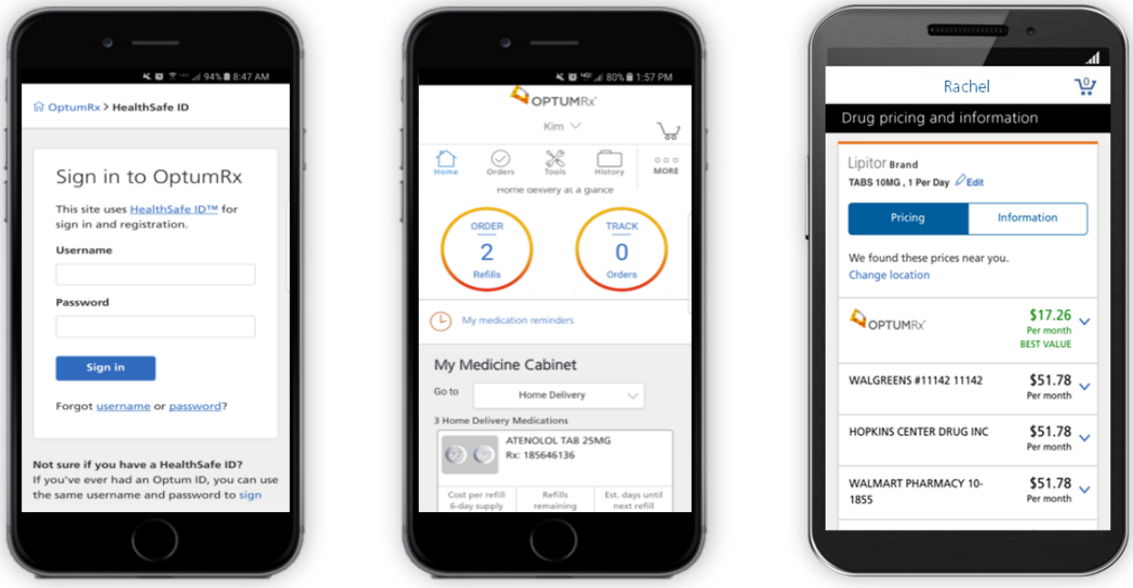
You could pay an average of 36 percent less for care by checking your costs on myuhc.com.



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 UHCApp** 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 both clients and 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

In an effort 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[1].

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.[2]

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[3]:

>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:

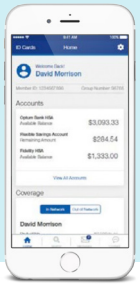
- Get health care cost estimates for specific treatments, procedures and medications
- Review hospital quality and safety data
- Receive real-time status on account balances, deductibles and out-of-pocket spending
- Find physicians and facilities nearby
- Track and manage claims
- Pay providers
- Access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

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.

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.



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 **UHC®** 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 the UHC App. 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®.

Meet your UnitedHealthcare Nurse Liaison!
Cathy Saunders, RN

Cathy can assist employees and their spouses/partners with the following:

- Help you and your family make better health care decisions
- Demonstrate how to navigate UnitedHealthcare tools and resources
- Provide health education and coaching to individuals, families
- Refer employees to appropriate Healthy Columbus programs and services
- Perform blood pressure/weight/BMI screenings
- Provide support with chronic illnesses like diabetes, hypertension and asthma

All information shared with Cathy is **100% confidential**

You can contact Cathy at:

Office Phone
614-645-NURS (6877)

Cell Phone
614-364-3777

Email
cathy.saunders@uhc.com or nurse@columbus.gov

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 **www.uhcpreventivecare.com** 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.uhcpreventivecare.com.***

Medical Necessity

Important changes in 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. With this in mind, we are introducing a new feature within your medical plan called ***Medical Necessity****. 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 or not 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.

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 Program

If cancer touches your life, this personalized program can help you manage your symptoms or side effects, and connect you with the care you need.

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.

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.

Orthopedic Health Support

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.

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

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 a Doctor*** > ***Behavioral Health Directory*** > ***People*** > ***Provider Type*** > ***Telemental Health Providers***.
2. Call the provider to set up an appointment.

Behavioral Health Benefits

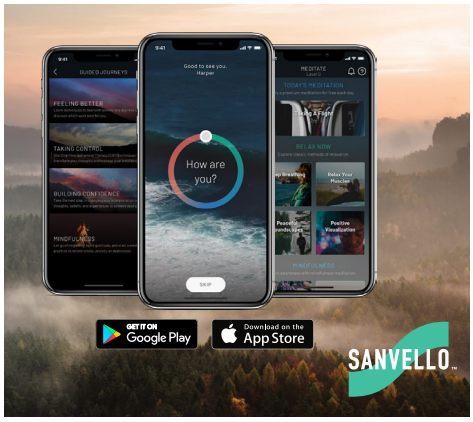
Say hello to Sanvello

On-demand help with stress, anxiety and depression.

Sanvello is an app that offers clinical techniques to help dial down the symptom of stress, anxiety and depression — anytime. Connect with powerful tools that are there for you right as symptoms come up. Stay engaged each day for benefits you can feel. Escape to Sanvello whenever you need to, track your progress and stay until you feel better.

Download the app today.

More information on **Sanvello.com**!



- **Daily Mood Tracking**
- **Coping tools**
- **Guided journeys**
- **Personalized progress**
- **Community support**

The Sanvello app is available to you at no extra cost as part of your plan's behavioral health benefits.

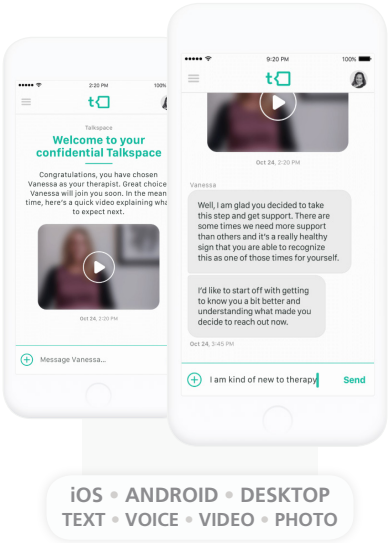
Behavioral Health Benefits

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.

talkspace



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.

Current Dental Coverage Summary: Delta Dental

Delta Dental PPO (Point-of-Service)
Summary of Dental Plan Benefits
For Group# 5866-6027, 9027 IAFF
City of Columbus

This Summary of Dental Plan Benefits should be read along with your collectively bargained contract and City of Columbus Benefits Booklet. Your collectively bargained contract and City of Columbus Benefits Booklet provides additional information about your Delta Dental plan, including information about plan exclusions and limitations. If a statement in this Summary conflicts with a statement in the collectively bargained contract and City of Columbus Benefits Booklet, the statement in this Summary applies to you and you should ignore the conflicting statement in the collectively bargained contract and City of Columbus Benefits Booklet, the statement in this Summary applies to you and you should ignore the conflicting statement in the collectively bargained contract and City of Columbus Benefits Booklet. The percentages below are applied to Delta Dental's allowance for each service and it may vary due to the dentist's network participation.*

Control Plan – Delta Dental of Ohio

Benefit Year – January 1 through December 31

Covered Services:	**Delta Dental PPO Dentist**	**Delta Dental Premier Dentist**	**Nonparticipating Dentist**
	Plan Pays	**Plan Pays**	**Plan Pays***
Diagnostic & Preventive			
Diagnostic and Preventive Services – exams, cleanings, fluoride, and space maintainers	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%
Major Restorative Services – crowns	75%	75%	75%
Other Basic Services – misc. services	75%	75%	75%
Relines and Repairs – to prosthetic appliances	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 –	treatment must begin prior to age 19 and coverage will continue to the end of treatment or until the maximum has been reached		

* 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.

- Oral exams (including evaluations by a specialist) are payable twice in any period of 12 consecutive months.
- Prophylaxes (cleanings) are payable twice in any period of 12 consecutive months. Benefits for periodontal maintenance procedures are unlimited.
- Fluoride treatments are payable twice in any period of 12 consecutive months with no age limit.
- Space maintainers are payable once per area per lifetime for people age 18 and under.
- Bitewing X-rays are payable twice in any period of 12 consecutive months and full mouth X-rays (which include bitewing X-rays) are payable once in any three-year period.
- Sealants are payable for first and second permanent molars and bicuspids for people age 18 and under. The surface must be free from decay and restorations.

Current Dental Coverage Summary:
Delta Dental, *continued*

- Composite resin (white) restorations are Covered Services on posterior teeth.
- Metallic inlays are Covered Services.
- Covered people under 17 years of age will receive stainless steel or prefabricated crowns only.
- Surgical periodontic services are payable first by the medical carrier, then will be a Covered Service under this plan secondary to medical.
- Most oral surgical services are payable first by the medical carrier, then will be a Covered Service under this plan, secondary to medical.
- Implants are payable once per tooth in any five-year period. Implant related services are Covered Services.
- Crowns over implants are payable once per tooth in any five-year period. Services related to crowns over implants are Covered Services.
- Limited and complete occlusal adjustments are not Covered Services. Antibiotic drug injections are Covered Services.
- X-rays taken for the purpose of Orthodontic evaluation will be paid at the Orthodontic benefit level.
- Diagnostic casts and photographs taken for the purpose of Orthodontic evaluation will be paid at the Orthodontic benefit level.

Having Delta Dental coverage makes it easy for you to get dental care almost everywhere in the world! You can now receive expert dental care when you are outside of the United States through our Passport Dental program. This program gives you access to a worldwide network of dentists and dental clinics. English-speaking operators are available around the clock to answer questions and help you schedule care. For more information, check our Web site or contact your benefits representative to get a copy of our Passport Dental information sheet.

Maximum Payment – $1,500 per person total per Benefit Year on all services except orthodontic services. $1,850 per person total per lifetime on orthodontic services.

Payment for Orthodontic Service – When orthodontic treatment begins, your Dentist will submit a payment plan to Delta Dental based upon your projected course of treatment. In accordance with the agreed upon payment plan, Delta Dental will make an initial payment to you or your Participating Dentist equal to Delta Dental's stated Copayment on 30% of the Maximum Payment for Orthodontic Services as set forth in this Summary of Dental Plan Benefits. Delta Dental will make additional payments as follows: Delta Dental will pay 75% of the per monthly fee charged by your Dentist based upon the agreed upon payment plan provided by your Dentist to Delta Dental.

Deductible – None.

Also eligible are your Spouse and your Children age 25 and under to the end of the calendar year in which they turn 26, including your Children who are married, who no longer live with you, who are not your dependents for Federal income tax purposes, and/or who are not permanently disabled.

Enrollees and dependents choosing this dental plan are required to remain enrolled for a minimum of 12 months. Should an Enrollee or Dependent choose to drop coverage after that time, he or she may not re-enroll prior to the date on which 12 months have elapsed. Dependents may only enroll if the Enrollee is enrolled (except under COBRA) and must be enrolled in the same plan as the Enrollee. An election may be revoked or changed at any time if the change is the result of a qualifying event as defined under Internal Revenue Code Section 125.

Coordination of Benefits – If you and your Spouse are both eligible to enroll in This Plan as Enrollees, you may be enrolled as both an Enrollee on your own application and as a Dependent on your Spouse's application. Your Dependent Children may be enrolled on both your and your Spouse's applications as well. Delta Dental will coordinate benefits between your coverage and your Spouse's coverage.

Benefits will cease on the last day of the month in which the employee is terminated.

Customer Service Toll-Free Number: 800-524-0149 (TTY users call 711)

https://www.DeltaDentalOH.com

Current Vision Coverage Summary: VSP

See Healthy and Live Happy With Help from the City of Columbus - IAFF and VSP

VSP Vision care for life

As a VSP® member, you get personalized care from a VSP network doctor at low out-of-pocket costs.

VALUE AND SAVINGS YOU LOVE.

Save on eyewear and eye care when you see a VSP network doctor. Plus, take advantage of Exclusive Member Extras for additional savings.

PROVIDER CHOICES YOU WANT.

PREMIER PROGRAM

With an average of five VSP network doctors within six miles of you, it's easy to find a nearby in-network doctor or retail chain. Plus, maximize your coverage with bonus offers and additional savings that are exclusive to Premier Program locations.

Prefer to shop online? Use your vision benefits on Eyeconic®—the VSP preferred online retailer.

QUALITY VISION CARE YOU NEED.

You'll get great care from a VSP network doctor, including a WellVision Exam®—a comprehensive exam designed to detect eye and health conditions.

Choose Your Perfect Pair

VSP members get an extra $20 to spend on featured frame brands. Plus, save up to 40% on lens enhancements.*

Get Your Perfect Pair:

EXTRA $20 TO SPEND ON FEATURED FRAME BRANDS*

bebe CALVIN KLEIN COLE HAAN FLEXON LACOSTE NINE WEST EYEWEAR

SEE MORE BRANDS AT **VSP.COM/OFFERS**.

+

UP TO **40%** SAVINGS ON LENS ENHANCEMENTS

EXCLUSIVE MEMBER EXTRAS

Contact us: **800.877.7195** or **vsp.com**

Current Vision Coverage Summary: VSP, *continued*

YOUR VSP VISION BENEFITS SUMMARY
THE CITY OF COLUMBUS - IAFF and VSP provide you with an affordable vision plan.

PROVIDER NETWORK:
VSP Choice
EFFECTIVE DATE:
01/01/2022 through 02/28/2022

Benefit	Description	Copay	Frequency
Your Coverage with a VSP Provider			
WellVision Exam	• Focuses on your eyes and overall wellness	$0	Every 12 months
PRESCRIPTION GLASSES			
Frame	• $135 allowance for a wide selection of frames • $155 allowance for featured frame brands • 20% savings on the amount over your allowance • $75 Costco® frame allowance	$0	Every 24 months
Lenses	• Single vision, lined bifocal, and lined trifocal lenses • Polycarbonate lenses for dependent children	$0	Every 12 months
Lens Enhancements	• Standard progressive lenses • Premium progressive lenses • Custom progressive lenses • Average savings of 20-25% on other lens enhancements	$55 $95 - $105 $150 - $175	Every 12 months
Contacts (instead of glasses)	• $150 allowance for exam, contacts, contact lens exam (fitting and evaluation) • 15% discount off WellVision Exam • 15% savings on a contact lens exam (fitting and evaluation)	$0	Every 12 months
EXTRA SAVINGS	**Glasses and Sunglasses** • Extra $20 to spend on featured frame brands. Go to vsp.com/offers for details. • 20% savings on additional glasses and sunglasses, including lens enhancements, from any VSP provider within 12 months of your last WellVision Exam.		
	Retinal Screening • No more than a $39 copay on routine retinal screening as an enhancement to a WellVision Exam		
	Laser Vision Correction • Average 15% off the regular price or 5% off the promotional price; discounts only available from contracted facilities		

Basic Group Term Life Insurance Benefit Highlights: Class 6

CITY OF COLUMBUS, CLASS 6

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	Life Coverage
Employee	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.

This Benefit Highlights document explains the general purpose of the insurance described, but in no way changes or affects the policy as actually issued. In the event of a discrepancy between this document and the policy, the terms of the policy apply. Benefits are subject to state availability. Policy terms and conditions vary by state. Complete details are in the Certificate of Insurance issued to each insured individual and the Master Policy as issued to the policyholder. The Hartford compensates both internal and external producers, as well as others, for the sale and service of our products. For additional information regarding Hartford's compensation practices, please review our website http://thehartford.com/group-benefits-producer-compensation. Life Form Series includes GBD-1000, GBD-1100, or state equivalent.

Basic Group Term Life Insurance Benefit Highlights: Fire Chiefs, Class 7

CITY OF COLUMBUS, CLASS 7

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	Life Coverage
Employee	Benefit: $100,000 or 1x annual salary whichever is greater, to a maximum of $200,000

ASKED & ANSWERED

Who is eligible?

You are eligible if you are an active full time City of Columbus IAFF Fire Battalion Chief or Deputy Chief 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 for you o n the 1st of month coinciding with or following your full time hire date. You must be actively at work with your em plo y er 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.

This Benefit Highlights document explains the general purpose of the insurance described, but in no way changes or affects the policy as actually issued. In the event of a discrepancy between this document and the policy, the terms of the policy apply. Benefits are subject to state availability. Policy terms and conditions vary by state. Complete details are in the Certificate of Insurance issued to each insured individual and the Master Policy as issued to the policyholder. The Hartford compensates both internal and external producers, as well as others, for the sale and service of our products. For additional information regarding Hartford's compensation practices, please review our website http://thehartford.com/group-benefits-producer-compensation. Life Form Series includes GBD-1000, GBD-1100, or state equivalent.

Life Insurance Information 2022: 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 you 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 2022: 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 families 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:

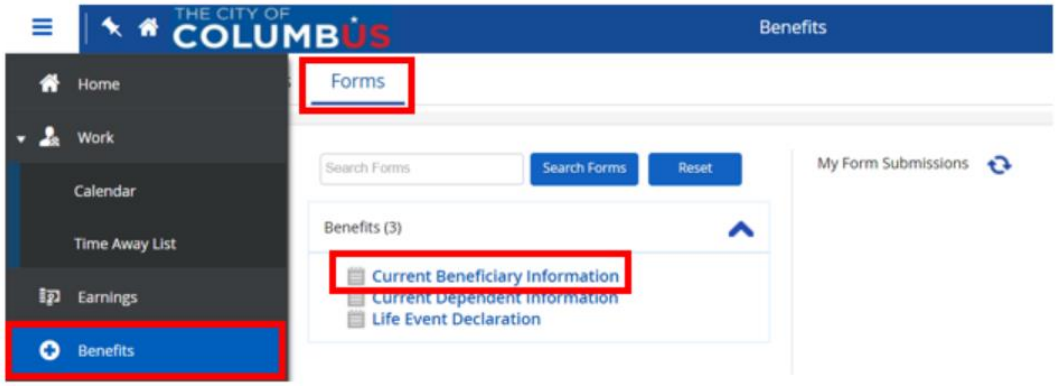
- Your employers name.
- Your phone number. Nature of the problem.
- Your employers group policy number: **GL-681893**
- Your travel assist ID number: **GLD-09012**

TheHartford.com/employeebenefits

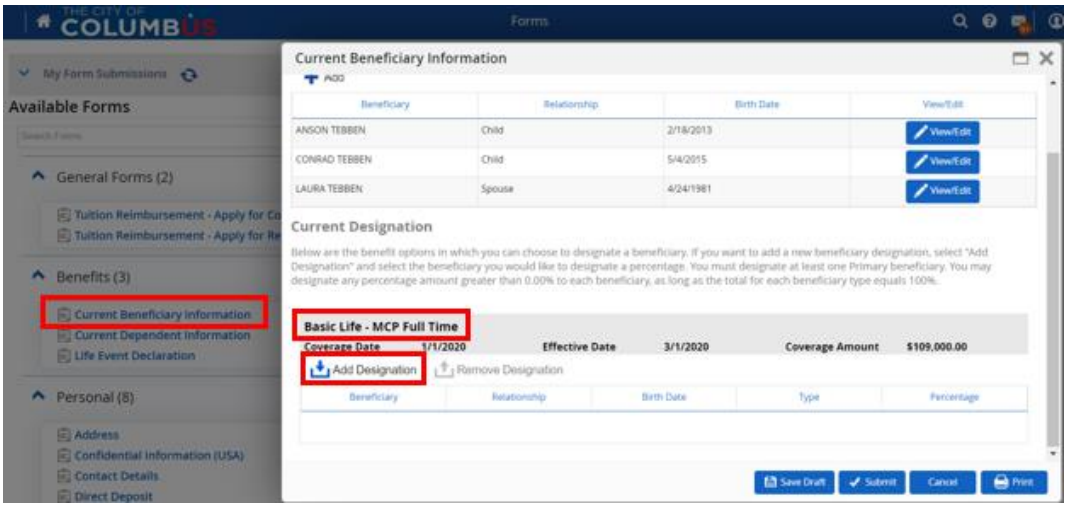
Updating Your Beneficiary Designation in Dayforce

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 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.

Your journey to better health 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 help make getting healthy more enjoyable. Plus you can earn rewards all along the way.

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. Already a member, just log in.

Take the health survey

The health survey is designed to help you assess your overall health. You'll use the results to help set your health goals.

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.

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, other members, or go for a personal best.

Get rewarded for getting healthy

Take at healthy actions to achieve your goals, and earn Rally coins redeemable for a variety of rewards.

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.

Ready to get started? Let's go!

rallyhealth.com/well

On your phone? Download the Rally app and register using the code BeWell.

How to Use Dayforce During HDHP Open Enrollment

STEP 1. Enter Dayforce with your login credentials.

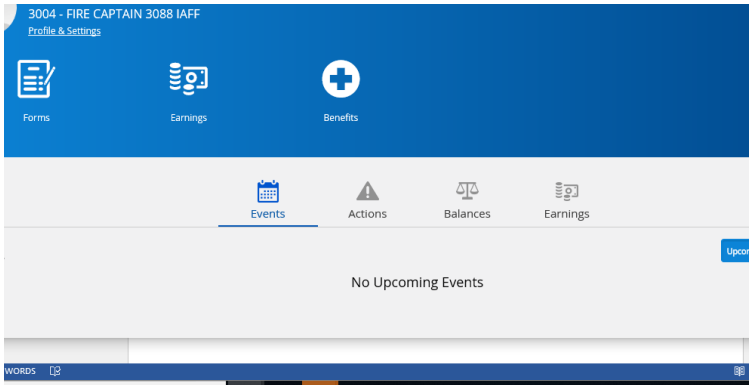
User Name is your employee ID number

Initial Password is birth year and last 4-digits of your social security number.

Ex. 19501234

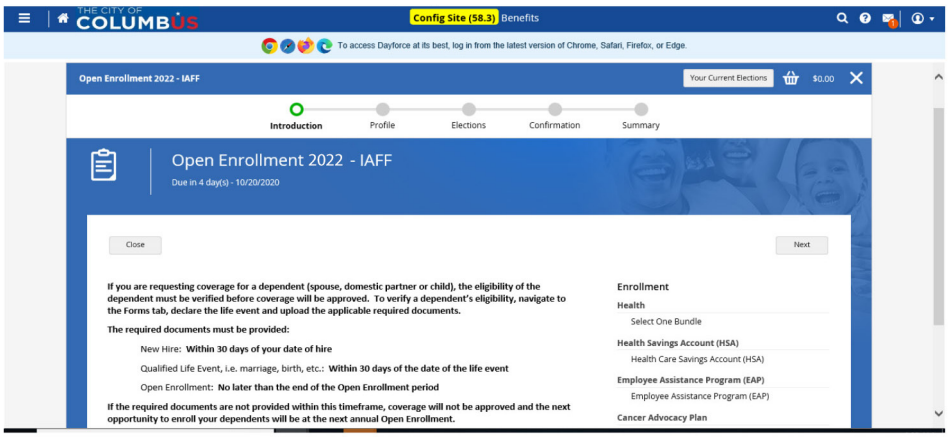
System will ask you to reset your password.

Click on “Benefits”



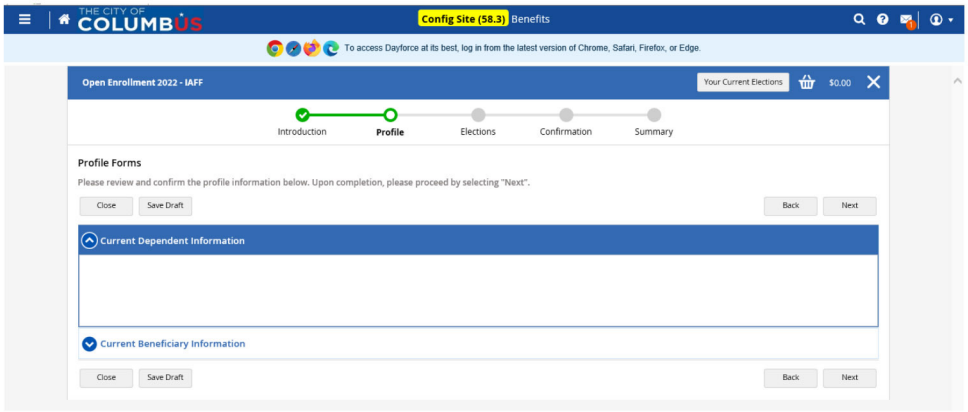
STEP 2. Once you are on the Benefits landing page click **“Start Enrollment”**

STEP 3. Read the Introduction page for additional details on enrollment and eligibility periods

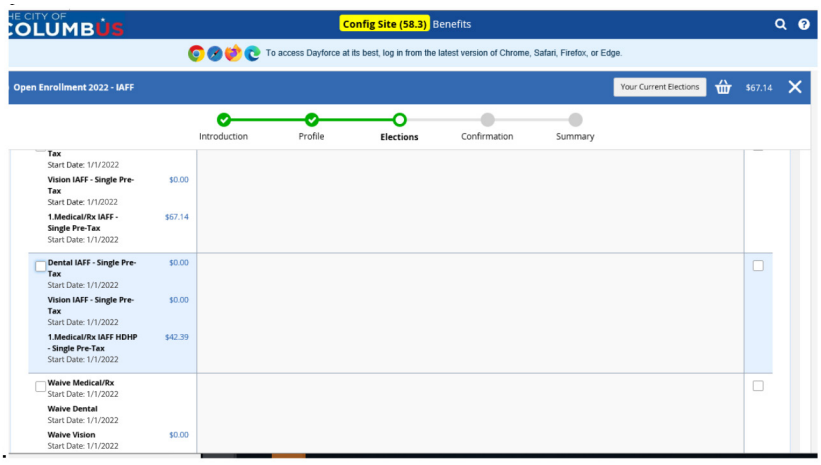


How to Use Dayforce During HDHP Open Enrollment, *continued*

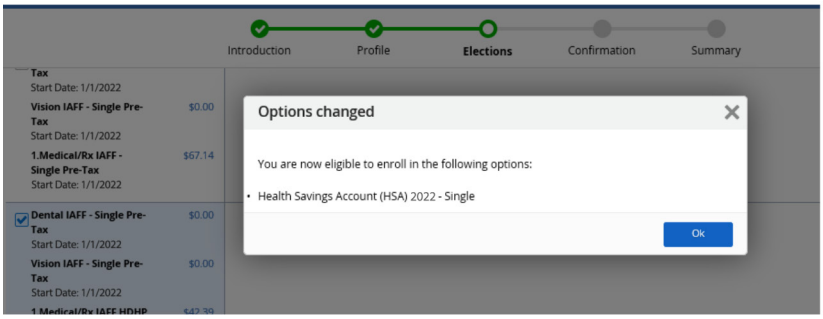
STEP 4. Click next on your profile page. Here you should see the names the City has on file as your dependents and/or beneficiaries. Please take this time to review and update your records.



STEP 5. Make your benefit elections. Remember this is the HDHP Open Enrollment. If you are currently in the traditional PPO and wish to maintain the traditional PPO click on the "X" and do nothing. If you wish to return to the traditional PPO from the HDHP click on the plan you wish to change to.

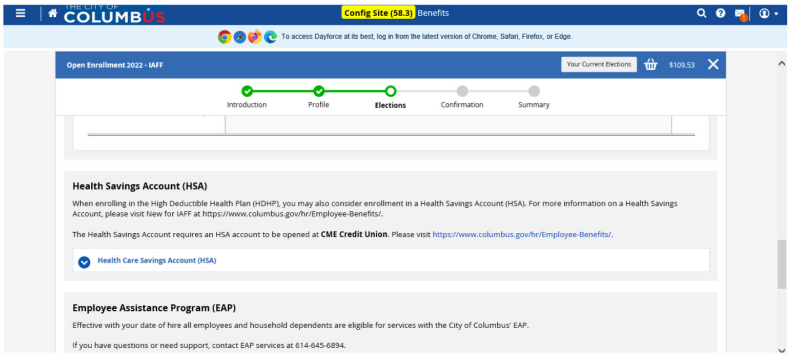


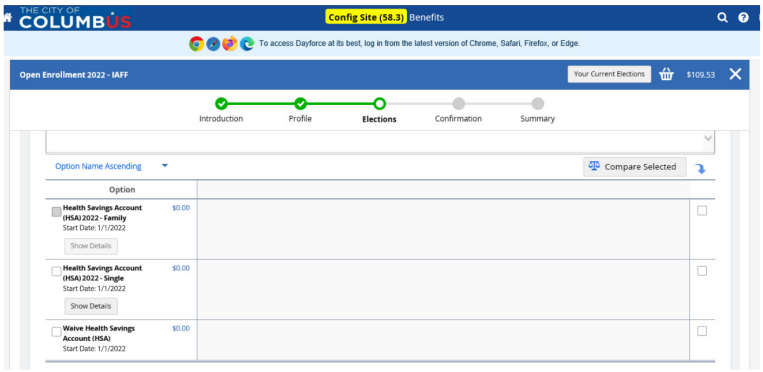
STEP 6. Once you elect the HDHP, the system will display a message that you are also eligible to enroll in the HSA for 2022.

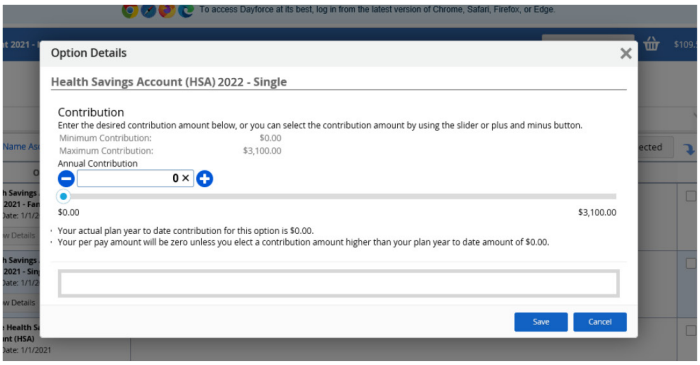


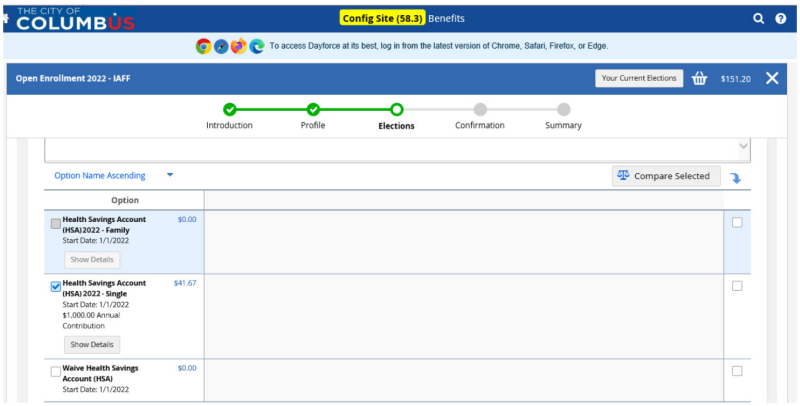
How to Use Dayforce During HDHP Open Enrollment, *continued*

STEP 7. Enter the amount you wish to contribute annually to the HSA bank account. If you are age 55 or older you can also elect the catch-up and contribute up to $1,000.00.



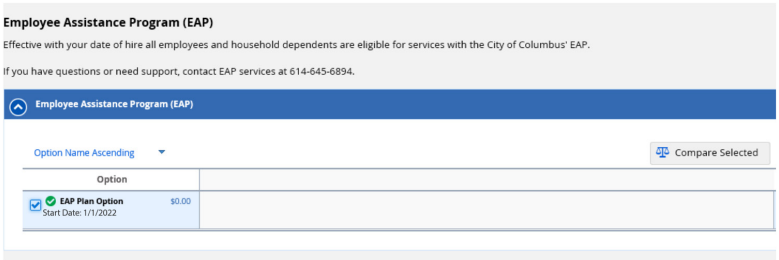


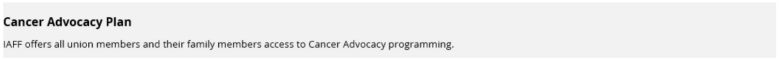


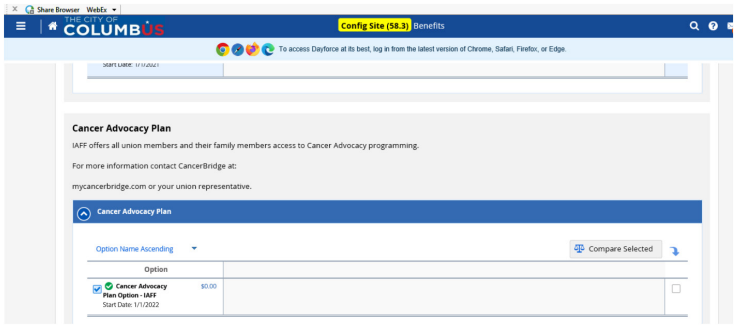


How to Use Dayforce During HDHP Open Enrollment, *continued*

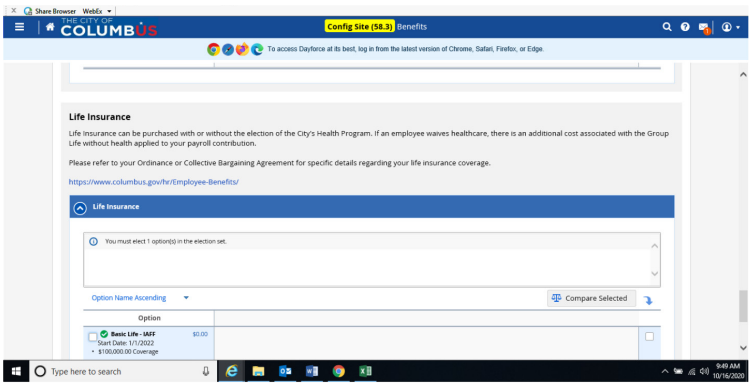
STEP 8. Confirm the box is checked for both the EAP and Cancer Advocacy Programs

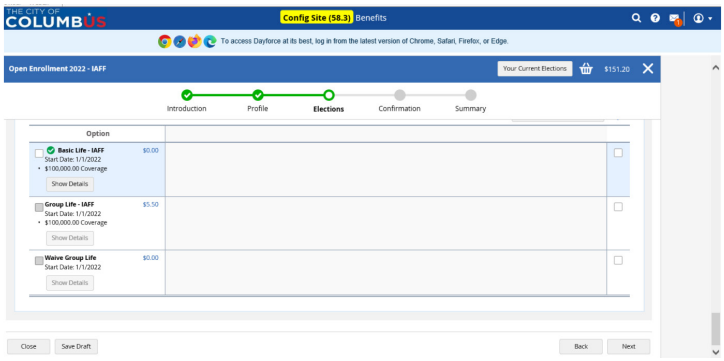






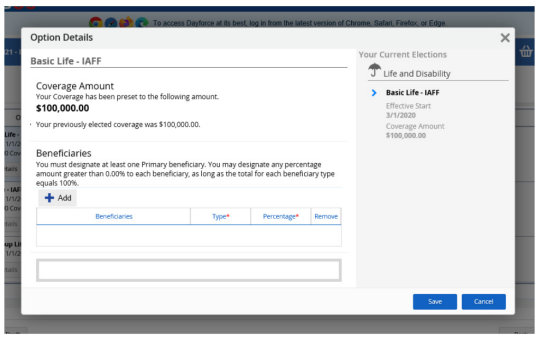
STEP 9. Click the box confirming your Basic Life insurance coverage. Then click next.



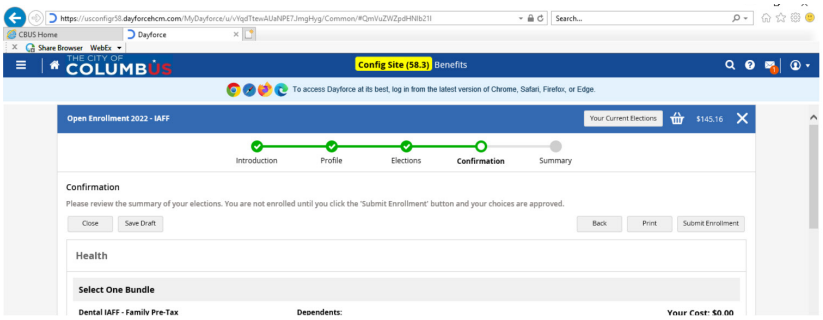


How to Use Dayforce During HDHP Open Enrollment, *continued*

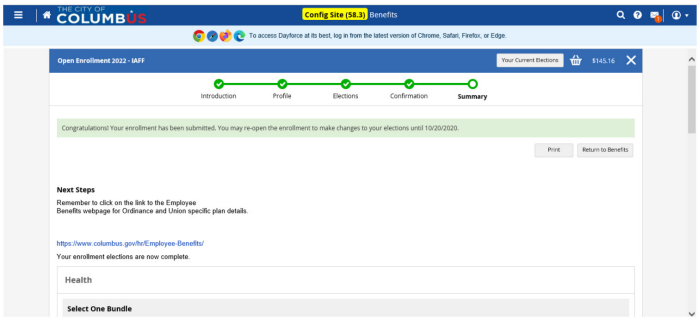
STEP 10. ALL EMPLOYEES must designate beneficiaries. Enter the type – Primary or Contingent. Then enter the percentage. Percentages must equal 100%. **You must enter your beneficiary designation before you move forward with the enrollment.** Click SAVE, then Next.



STEP 11. Confirmation Page. Review Elections and confirm everything looks correct before clicking on next.



STEP 12. Print your Summary Statement for your records to compare to the first pay period in January 2022. After printing, click return to Benefits, your status will read “submitted” in green. Logout of the system. Your Enrollment is complete.



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 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/HR-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	**One (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 2 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** **Three (3) of the following documents to show financial interdependency**: - 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.	**<u>One</u> (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), <u>one</u> (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 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 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) 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 guardianship of the child as well.	**<u>One</u> (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 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 birth certificate of stepchild, 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.	**<u>One</u> (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:** 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).	**<u>One</u> (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

- IAFF will have a **Open Enrollment** period from November 7th through December 4th 2021 for the for the HDHP with HSA with an effective date of January 1, 2022.
- The **Open Enrollment** period is November 7th through December 4th for the HDHP with HSA.
- Employees that enroll during **Open Enrollment** period can only enroll in the HDHP with HSA, unless the employee is returning to the Traditional PPO.
- Employees that DO NOT enroll in the HDHP with HSA, will complete their **2022 Open Enrollment** in February 2022.
- Employees will not be allowed to change coverage during the February **Open Enrollment** period.
- Employees cannot opt out of the HDHP with HSA during February 2022 **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, 2022 will have 30 days to enter the requested change in the Dayforce employee self-service system.
- 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 are required to actively elect an HSA dollar amount annually. This amount must be determined at open enrollment.
- Employees will need to complete both an active election into the HDHP and make an 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 $300 in January and July for single coverage available in January for single coverage.
- City of Columbus will contribute $600 in January and July for family coverage available in January for family coverage.
- 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.**

Where do I get more information?

- Additional Information available on IAFF's Local 67 website and the Employee Benefits Website under New for 2022.

Important information on the following pages:

CME Federal Credit Union HSA Account Instructions

Pages 45-46

NICHOLE M. BRANDON
Director

The City of Columbus

Employee Health Care Contributions by Uniform Group

April 1, 2021 - March 31, 2022

IAFF PPO	Single	$117.28
	Family	$293.20
IAFF HDHP	Single	$67.28
	Family	$163.20

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

Notes

THE CITY OF
COLUMBUS
ANDREW J. GINTHER, MAYOR

DEPARTMENT OF
HUMAN RESOURCES