THE CITY OF
COLUMBUS
ANDREW J. GINTHER, MAYOR

DEPARTMENT OF
HUMAN RESOURCES

Open Enrollment 2023:

Open Enrollment is January 23rd –February 28th, 2023.

Review the enclosed information to learn more about:

- Medical & Pharmacy Coverage
- Clinical Programs
- Dental Coverage
- Cancer Advocacy - IAFF, OLC, HACP and MCP Ordinance Groups
- Front Street Fitness Services and Resources
- Vision Coverage
- Basic Life Insurance - Beneficiary Designation
- Health Engagement Office - New Location
- Dayforce Employee Self Services - Open Enrollment Navigation tips

Wellness Programming – RALLY.

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

Health Engagement Nurses

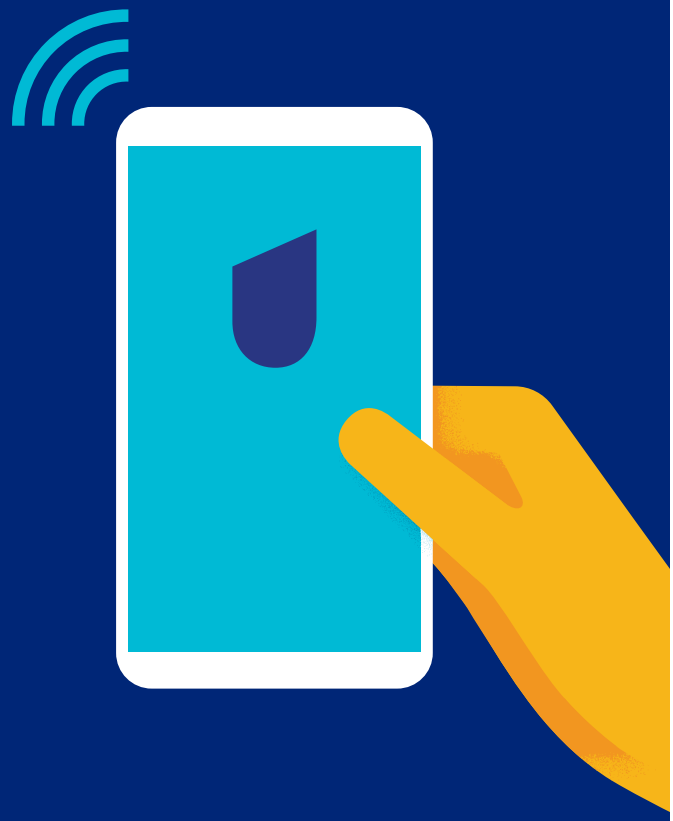
Have you met our **NEW** Health Engagement Nurses? Health Engagement Nurses can assist with nutrition, physical and mental health support, referrals to internal and external resources and one on one confidential consultations. Meet **Whitney Smith** and **Wendy Karcher** later in this booklet.

More information about your Employee Benefits and Wellness is available at **www.columbus.gov/hr/Employee-Benefits** or by calling **614-645-8624**.

United Healthcare

We're reaching out for a caring conversation.

It's your health. Let's connect on it.



A compassionate UnitedHealthcare nurse or advocate may be reaching out to offer extra support. They may be trying to contact you to help schedule appointments, enroll you in complimentary programs, help fill prescriptions and answer your questions.

We may be connecting with those who are:

Recovering from a hospital stay

We'll confirm that you've received and understand your after-care instructions, medications, etc.

Managing a condition

We'll reach out to provide caring assistance to those with cancer, asthma, diabetes, heart failure, kidney issues and more.

Expecting a baby

If pregnant, an experienced maternity nurse may call to provide support.

Missed our call?

Call the number on your health plan ID card.

You can also stop by the Health Engagement Office Monday through Friday from 8:00 am to 4:30 pm. Just call and setup a confidential appointment at 614-645-NURS (6877).

Health Care and Pharmacy Benefits: AFSCME 1632 & 2191, CWA, HACP, MCP and OLC Members

	Network (Participating Providers)	Non-Network (Non-Participating Providers)
Annual Deductible		
Individual /Family	$300/$600	$800/$1,600
Out of Pocket Maximum	$700/$1,200	$1,600/$3,200
Co-Insurance	20%	40%
Physician Services		
Primary Care Office Visit	$20	Deductible, then 40%
Specialist Office Visit	$30	Deductible, then 40%
Emergency Care		
Emergency department	$75, Deductible, then 20%	$75, Deductible, then 20%
Urgent care	$30, Deductible, then 20%	$30, Deductible, then 40%
Hospital In-Patient Services		
	Deductible, then 20%	Deductible, then 40%
Ambulatory Services		
Diagnostic lab/x-ray	Deductible, then 20%	Deductible, then 40%
Ambulatory surgery center	Deductible, then 20%	Deductible, then 40%
Mental Health and Substance Abuse		
In-patient services	Deductible, then 20%	Deductible, then 40%
Out-patient mental/drug/alcohol	Deductible, then 20%	Deductible, then 40%
Preventive Care		
Physician office visit	0%	Deductible, then 40%

	Retail	Mail Order
Pharmacy		
Tier 1	$5	$12.50
Tier 2	$15	$25
Tier 3	$30	$60

Your pharmacy plan includes a separate maximum out of pocket for medications. These amounts represent the maximum amount that you would pay for the year for prescriptions. If you reach the maximum out of pocket, your copays will be $0. These amounts are based on whether you have individual or family coverage.

	Individual OOP	Family OOP
Pharmacy Out-of-Pocket-Maximum		
	$2,000	$4,000

Health Care and Pharmacy Benefits: FOP Members

	Network (Participating Providers)	Non-Network (Non-Participating Providers)
Annual Deductible		
Individual /Family	$300/$600	$800/$1,600
Out of Pocket Maximum	$700/$1,200	$1,600/$3,200
Co-Insurance	10%	40%
Physician Services		
Primary Care Office Visit	Deductible, then 10%	Deductible, then 40%
Specialist Office Visit	Deductible, then 10%	Deductible, then 40%
Emergency Care		
Emergency department	Deductible, then 10%	Deductible, then 10%
Urgent care	Deductible, then 10%	Deductible, then 40%
Hospital In-Patient Services		
	Deductible, then 10%	Deductible, then 40%
Ambulatory Services		
Diagnostic lab/x-ray	Deductible, then 10%	Deductible, then 40%
Ambulatory surgery center	Deductible, then 10%	Deductible, then 40%
Mental Health and Substance Abuse		
In-patient services	Deductible, then 10%	Deductible, then 40%
Out-patient mental/drug/alcohol	Deductible, then 10%	Deductible, then 40%
Preventive Care		
Physician office visit	0%	Deductible, then 40%

	Retail	Mail Order
Pharmacy		
Tier 1	$5	$12.50
Tier 2	$15	$25
Tier 3	$30	$60

Your pharmacy plan includes a separate maximum out of pocket for medications. These amounts represent the maximum amount that you would pay for the year for prescriptions. If you reach the maximum out of pocket, your copays will be $0. These amounts are based on whether you have individual or family coverage.

	Individual OOP	Family OOP
Pharmacy Out-of-Pocket-Maximum		
	$2,000	$4,000

Health Care and Pharmacy Benefits: IAFF Members

	Network (Participating Providers)	Non-Network (Non-Participating Providers)
Annual Deductible		
Individual /Family	$300/$600	$800/$1,600
Out of Pocket Maximum	$700/$1,200	$1,600/$3,200
Co-Insurance	20%	40%
Physician Services		
Primary Care Office Visit	Deductible, then 20%	Deductible, then 40%
Specialist Office Visit	Deductible, then 20%	Deductible, then 40%
Emergency Care		
Emergency department	Deductible, then 20%	Deductible, then 20%
Urgent care	Deductible, then 20%	Deductible, then 40%
Hospital In-Patient Services		
	Deductible, then 20%	Deductible, then 40%
Ambulatory Services		
Diagnostic lab/x-ray	Deductible, then 20%	Deductible, then 40%
Ambulatory surgery center	Deductible, then 20%	Deductible, then 40%
Mental Health and Substance Abuse		
In-patient services	Deductible, then 20%	Deductible, then 40%
Out-patient mental/drug/alcohol	Deductible, then 20%	Deductible, then 40%
Preventive Care		
Physician office visit	0%	Deductible, then 40%

	Retail	Mail Order
Pharmacy		
Tier 1	$5	$12.50
Tier 2	$15	$25
Tier 3	$30	$60

Your pharmacy plan includes a separate maximum out of pocket for medications. These amounts represent the maximum amount that you would pay for the year for prescriptions. If you reach the maximum out of pocket, your copays will be $0. These amounts are based on whether you have individual or family coverage.

	Individual OOP	Family OOP
Pharmacy Out-of-Pocket-Maximum		
	$2,000	$4,000

Medical and Pharmacy:

Understanding Non-Network Expenses

We encourage you to take an active role in your health care and learn which doctors, health care professionals and facilities participate in the UnitedHealthcare network so you can better understand expenses that may come with using non-network (sometimes called "out-of-network") providers.

Did you know you will pay less for in-network providers?

Visit **myuhc.com** or call Customer Care at **1-800-681-3849** to find an in-network provider.

Understand the costs for care outside the UnitedHealthcare network

Doctors, facilities and laboratories that do not participate in the UnitedHealthcare network are free to set their prices for the care and services they provide. They do not offer services at a discounted rate because they do not participate in the UnitedHealthcare network. As a result, your cost sharing will be higher, and there may be other costs such as balance billing.

When you use non-network doctors, facilities and laboratories for anything other than emergency care, you will pay higher deductible and coinsurance amounts for similar services had you used a health care provider who participates in UnitedHealthcare's network.

Reimbursement for non-network charges is based on 140% of the rates allowed by Medicare. This is called the Maximum Non-Network Reimbursement Program, or "MNRP."

Using in-network doctors and facilities

Doctors and facilities (including laboratories) who participate in the UnitedHealthcare network have agreed to provide services to you at a discount in exchange for obtaining access to provide you services. You have access to a large network of more than 720,000 doctors and health care specialists and more than 5,600 hospitals. When you use the UnitedHealthcare network, you are responsible for paying your in-network expenses such as deductibles and coinsurance rather than higher non-network deductibles and coinsurance.

What you should do

If you don't have a doctor, find a doctor now who participates in the UnitedHealthcare network. You will save yourself time when you aren't feeling your best and need to see a doctor. If you have a doctor already, make sure your doctor participates in the UnitedHealthcare network. To find out if your doctor or other health care professional participates in the UnitedHealthcare network, use the online directory on myuhc.com® or call the Customer Care number on the back of your medical ID card. It is your responsibility to confirm that the doctor, facility or laboratory participates in the UnitedHealthcare network in order to receive network benefits.

Medical and Pharmacy:

Understanding Non-Network Expenses, *continued*

The network delivers real value

The following examples show how your financial responsibility will be significantly lower when you seek care from a doctor in the UnitedHealthcare network rather than outside the network.

Physician's office visit and facility claims examples for the Maximum Non-Network Reimbursement Program (MNRP)

Example 1

Physician office visit claim

	Network	Non-Network
Billed charge amount	$270	$270
Eligible expense (amount UnitedHealthcare allows)	$120	$150 (MNRP pricing)
20% Network coinsurance/ (after deductible has been met)/40% non-network co-insurance (after deductible has been met)	$24	$60
Additional enrollee responsibility	$0	$120*
Member financial responsibility	**$24**	**$180**

*This amount does not apply to the out-of-pocket maximum.

Example 2

Facility claim

	Network	Non-Network
Billed charge amount	$3,700	$3,700
Eligible expense (amount UnitedHealthcare allows)	$1,500	$1,740 (MNRP pricing)
Deductible	$300	$800
20% Network coinsurance/ 40% non-network coinsurance	$240	$376
Additional member responsibility	$0	$1,960*
Member financial responsibility	**$540**	**$3,136**

What can I do to help keep my costs down?

Use network doctors and facilities.
If you don't have a network doctor, you can use myuhc.com® or call Customer Care to find network facilities and doctors near you.

Talk to your doctor.
Before you have a health care procedure, be sure to ask your doctor if the facility and all other doctors who may be involved participate in your plan network.

Use these tools.
Find & Cost Care shows you the estimated cost for a treatment or procedure, and how that cost is impacted by your deductible, coinsurance and out-of-pocket maximum.

The UnitedHealthcare mobile app lets you easily access your health care information and gives you tools to help estimate costs, manage claims and find providers – anytime and anywhere. It's built to be your go-to health care resource when you're on the go. You use the same log-in and password for MyUHC.com and the UnitedHealthcare app.

Medical and Pharmacy:

Medical Necessity

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

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

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

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

Prior Authorization

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

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

NOTE: This program does not apply to FOP members.

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.

Free Blood Glucose Monitor Program

Helping you manage your diabetes.

Diabetes may harm your eyes, kidneys, nerves, heart and blood vessels. The impact can be long-term. Regular blood sugar testing can help you manage your diabetes and may lead to better glucose control.

Take advantage of this great offer

To help you monitor blood sugar levels, your pharmacy benefit plan offers a free One Touch or Contour Next meter program.* With this program, you are able to get a blood sugar meter at no charge to you. You and your doctor can choose from a variety of meters. For more details, call customer service at the phone number on your health plan ID card, or contact the meter manufacturer at the numbers to the right under the manufacturer's meter you are interested in.

How to get your free meter

1. Discuss with your doctor and select the meter that is best for you.
2. Once you decide, contact the manufacturer directly.
3. The meter will arrive by mail 3–7 days after placing the order.

*One free meter per member. Other restrictions may apply.

Choose from these brand-name meters

To order one of these OneTouch® meters call **1-800-845-9525** or visit the website at **https://www.onetouch.orderpoints.com.**

Order Code: 236DMT001

OneTouch®
Blood Glucose Monitors

OneTouch Verio® IQ Meter
uses OneTouch Verio® Test Strips

OneTouch Verio® Reflect Meter
uses OneTouch Verio® Test Strips

To order one of these CONTOUR®NEXT meters call **1-800-401-8440** or visit the website at **ContourNextFreeMeter.com**.

Order Code: BDC-UHC

CONTOUR®NEXT
Blood Glucose Monitors

CONTOUR®NEXT meter
uses CONTOUR®NEXT test strips

CONTOUR®NEXT EZ meter
uses CONTOUR®NEXT test strips

CONTOUR®NEXT ONE meter
uses CONTOUR®NEXT test strips

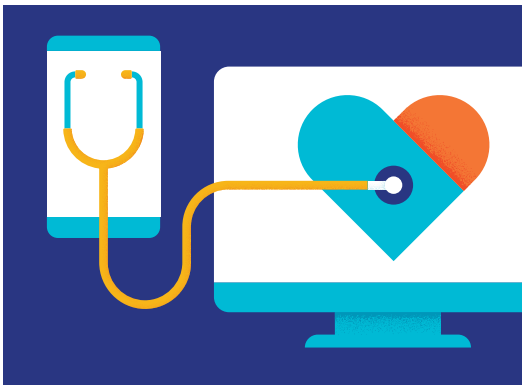
Medical and Pharmacy Resources and Tools:

Activate your myUHC.com account

Get the most out of your benefits

Your personalized website, **myuhc.com®**, features tools designed to help you:

- Find, price and save on care — you can save with Virtual Visits and other tools. You can save an average of 36% when you compare costs for providers and services
- Get care from anywhere with Virtual Visits. A doctor can diagnose common conditions by phone or video 24/7
- Understand your benefits and the financial impact of care decisions
- Find tailored recommendations regarding providers, products and services. You can even generate an out-of-pocket estimate based on your specific healthplan status
- Access claim details, plan balances and your health plan ID card quickly
- Follow through on clinical recommendations and access wellness programs
- Order prescription refills, get estimates and compare medication pricing
- Check your plan balances, access financial accounts and more



Scan the QR code to visit myUHC.com

Activation is quick

1. Go to **myuhc.com** > **Register Now**.
2. Fill out the required fields and create your username/password.
3. Enter your contact information and security questions.
4. Agree to the website's policies and be sure to opt-in for email updates. We promise you'll only see our name in your inbox with relevant news and wellness updates.

Get started at myuhc.com

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.

Know Before You Go:

Right Care. Right Place. Right Savings.

With many options for getting care, how do you choose? This chart can help you understand where to go for what – and how you can save money.

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?

Cost Comparison Tools:

How can I research medical care?

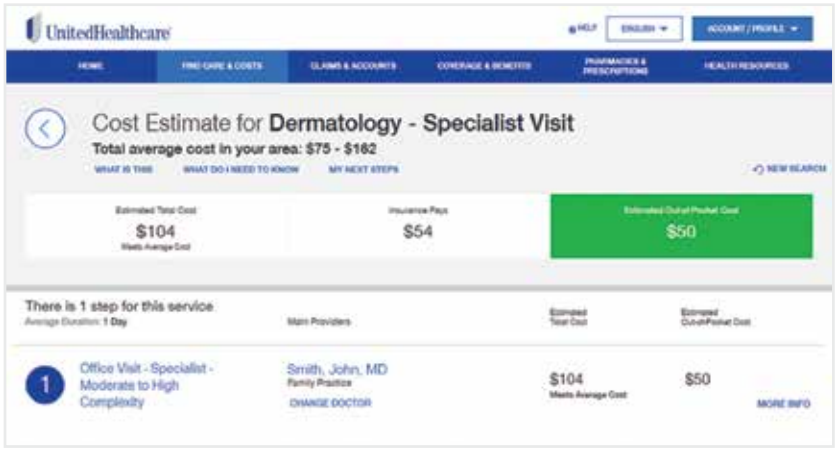
When you're deciding where to go for care, take a look at cost, as well as quality and convenience. Often you can get the care you need — and save money at the same time. Just go to ***myuhc.com*** *to:*

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.

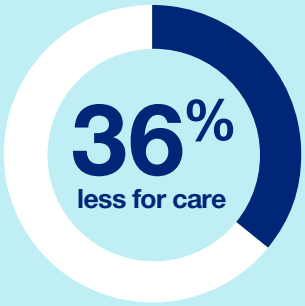
Get personalized estimates.

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.

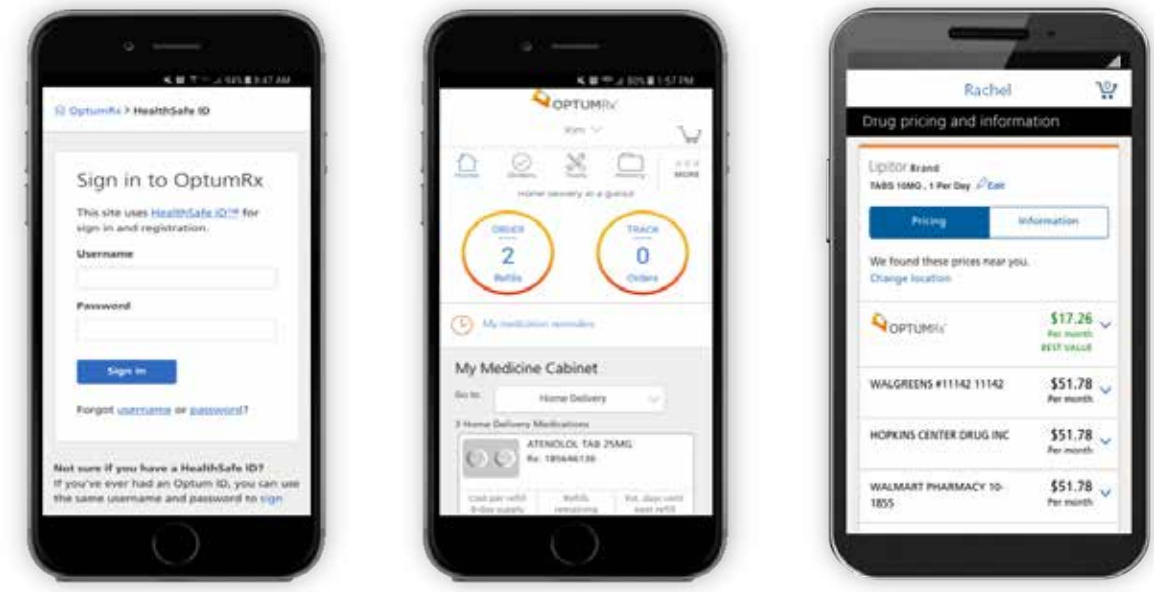


It's all in one easy-to-use search tool!

Cost Comparison Tools:

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.

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

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

Pharmacy: Prior Authorization Includes Notification and Medical Necessity

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

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

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

Obtaining prior authorization before a medication is covered:

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

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

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

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

How do we determine prior authorization programs?

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

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

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

Pharmacy: Prior Authorization, *continued*

Innovative programs and tools

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.

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

Medical Diagnosis to Script program:

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

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

PreCheck MyScript:

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

>30% prior authorizations avoided or initiated.

Your UnitedHealthcare Health Engagement Nurses can help you achieve your health goals!

Wendy Karcher, MSN, RN

Wendy_Karcher@UHC.com

Whitney Smith, MSN, RN

Whitney_Smith@UHC.com

Call 614-645-6877 and you can choose to speak with either Nurse Wendy or Nurse Whitney.

Nurse Wendy & Nurse Whitney are here to support City of Columbus employees, spouses/domestic partners, and eligible dependents with the following:

- Health promotion and prevention through sound health care decisions and education.
- Navigation of UnitedHealthcare tools and resources and referral to appropriate wellness programs and services.
- Health education to individuals and groups.
- Support for chronic conditions such as diabetes, heart disease, hypertension, asthma, and many others.
- Finding health care providers that fit your needs.

All interactions with your Health Engagement Nurses are at no cost to you and 100% confidential

Office Phone
614-645-NURS (6877)

Email
nurse@columbus.gov

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 condition treatment
- 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™, Teladoc®** and **Optum Virtual Care.**

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®.

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

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

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.

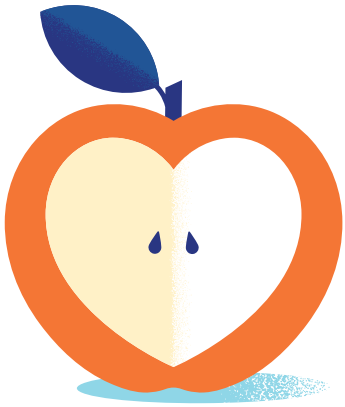
You can easily access some of these services by calling the number on your health plan ID card.

Your journey to a healthier lifestyle begins here.

Welcome to Rally

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

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



1. Register and create your Rally profile

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

2. Take the health survey

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

3. Get personalized recommendations

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

4. Choose healthy activities to hit your goals

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

5. Get rewarded for getting healthy

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

6. Dive into communities

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

Visit **myuhc.com®** > ***Health Resources*** > ***Rally***
or visit **rallyhealth.com**

Behavioral Health Benefits:

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

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

Virtual therapy offers confidential counseling and includes:

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

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

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

Virtual therapy is designed to help treat conditions like:

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

A quicker way for the whole family to get care.

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

To find a provider and schedule a visit:

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

Behavioral Health Benefits:

Self Care: On-demand help for stress, anxiety and depression

The current self-guided wellness app Sanvello will be transitioning to the new Self Care app throughout 2023.

The Self Care app features:

- 24/7 self-paced digital program with no out-of-pocket member costs
- Industry-recognized clinical assessments* help users track behaviors over time (PHQ-9, GAD-7, WHO-5)
- Evidence-based mental health support including assessments, trackers, mental health skills and tools, collections and communities

Measurable outcomes: Symptoms of depression, anxiety and stress improved for individuals using our Self Care app[1]

Available via app or web experience on mobile device, tablet or computer

Self Care app: Four types of support

Assessments and tracking

Mood tracking and assessments help members understand their emotional state, track progress, and access focused content, tools and support

Collections

Topical content helps members learn and apply skills relevant to specific needs or situations

Mental health resources and tools

Clinical tools and techniques help members learn and practice evidence-based mental health tactics to build long-term life skills

Community

Structured chats and message boards invite peer-to-peer discussions and allow users to connect and learn from one another*

* The Patient Health Questionnaire-9 (PHQ-9) scores each of the 9 Diagnostic and Statistical Manual of Mental Disorders criteria based on the mood module from the original PRIME-MD. It was developed by Drs. R.L. Spitzer, J.B.W. Williams, K. Kroenke and colleagues, and an educational grant from Pfizer, Inc. The Generalized Anxiety Disorder Scale-7 (GAD-7) is a 7-item , self-rated scale developed by Spitzer and colleagues (2006) as a screening tool and severity indicator for GAD. The World Health Organisation – Five (WHO-5) is a short self-reported measure of current well being. The measure was first introduced in 1988 by the WHO Regional Office in Europe.

[1] Provided by AbleTo. Based on 2021 Sanvello™ participants from national client that opted into self-care only, had above-normal DASS symptom scores and completed assessment at least twice. AbleTo is majority owned by OptumHealth Holdings, LLC, a UnitedHealthcare affiliate.

Behavioral Health Benefits:

Message a dedicated therapist any time, anywhere with Talkspace

Something on your mind?

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

Make progress. No office visit required.

Here's how Talkspace can fit your life:

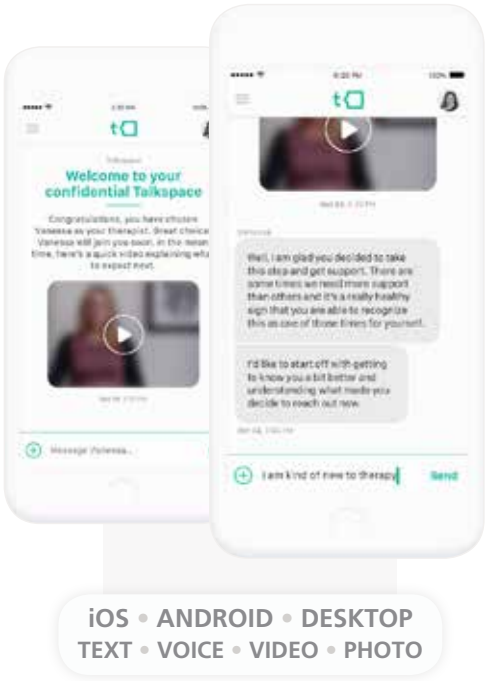
- With Talkspace, you can message a licensed therapist, 24/7.
- Find a therapist with an online matching tool.
- Start therapy within hours of choosing your therapist.
- Therapists respond daily, five days a week.
- Schedule live video sessions, when needed.
- Download the Talkspace app on your smartphone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

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

Talkspace is convenient, safe and secure.

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

talkspace



*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.

2023 Dental Benefits: Non-Uniform

Covered Services

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

Frequency

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

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

2023 Dental Benefits: Uniform

Covered Services

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

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Crowns over Implants	Once per tooth in any 5 year period
Sealants – Age 18 and under	First and second permanent molars and bicuspids which are free from decay and restorations

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

Delta Dental

Your dental benefits, at your fingertips!

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

» Coverage and claims information

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

» Dental Care Cost Estimator

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

» Dentist search

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

» Mobile ID card

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

» Toothbrush timer

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

Get started

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

SCAN TO DOWNLOAD APP

Log in for secure access

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

Delta Dental

Pre-treatment estimates help you avoid surprises

Unexpected bills aren't fun for anyone. It's much easier to budget for expenses you're expecting. That's why Delta Dental makes it easy for you to find out whether a proposed dental treatment is covered, what amount the plan will pay and the difference you will be responsible for.

Here's how: When you are having extensive work done and want to know what your share of the cost will be, ask your dentist to submit the proposed treatment plan to us for a pre-treatment estimate. A pre-treatment estimate gives us a chance to review the proposed treatment in accordance with your dental coverage. We can then determine what portion of the treatment will be covered under the plan chosen by your employer, if you will exceed your maximum and what portion will be your financial responsibility.

We'll send a pre-treatment estimate notice to you and your dentist. We encourage you to review this notice together and discuss treatment options before deciding on treatment.

With a pre-treatment estimate, you'll know ahead of time how much of the bill you'll be responsible for. A pre-treatment estimate gives you the opportunity to learn about your options—and it makes it easier for you to budget for your dental care.

NOTE: A pre-treatment estimate is NOT a guarantee of future dental benefits or payment. When the services are complete, Delta Dental will calculate its payment based on your current eligibility, remaining maximum and any deductible requirements.

EYEMED 2023 Vision Benefits:
FOP and IAFF

40% OFF
additional complete pair of prescription eyeglasses

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

Find an Eye Doctor
(Insight Network)

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

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

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

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

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

EYEMED 2023 Vision Benefits:
AFSCME, CWA, HACP, MCP and OLC

40% OFF
additional complete pair of prescription eyeglasses

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

Find an Eye Doctor
(Insight Network)

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

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

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

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

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

EyeMed Vision Benefits

City of Columbus
EyeMed Vision Care Diabetic Product

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

Benefit Frequency: All Diabetic Care Services are covered once every 6 months*

Vision Care Definitions

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

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

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

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

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

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

Using Your EyeMed Benefits

Time to get the eyewear you love! But how does it work? Even if you're a vision benefits rookie, the process is a snap. Tailor-made for paperwork-phobes and freedom fans.

1. Know the benefits. Your Welcome Kit spells out all the great stuff that's covered. All the savings opportunities. All the choices you have. It's a pretty fun read.

2. Choose a Doc. You're probably surrounded by in-network doctors: thousands of independent providers, popular retail stores and even online options. Find your ideal fit on eyemed.com or on the EyeMed Members App.

3. Set a date. Just call your eye doctor for an appointment. Even better, some let you schedule online with our Provider Locator. If you need weekend or evening hours, you'll find plenty of those, too.

4. Come on in. As an EyeMed member, it's easy to get your eye exam and get on with your day. No claim to file. No hassles. We take it from here.

5. Find your perfection. Have fun picking out your favorite frames or contacts. Browse loads of designer brands; you decide which price point works best for you. With EyeMed, there's more in the store to adore.

Know Before You Go

With EyeMed's **Know Before You Go** out-of-pocket cost estimator, you can get a feel for what you might pay before you even step foot into a store or doctor's office. The tool includes simple, clear definitions of common products and add-ons, all while calculating a range of costs with each click. So you can feel confident from check-in to check-out.

1. **Log into eyemed.com and find our Know Before You Go out-of-pocket cost estimator.**
2. **Pick the type of exam you'll need. Just need glasses or contacts? Take a look at Step 3.**
3. **Choose from a variety of lens types, options and add-ons. Plus, get detailed descriptions of each product so you feel confident in your choices.**
4. **The best part? You get a range of costs based on your choices and applied vision benefits. We do the math so you stay in-the-know before you go.**

Register on eyemed.com to try Know Before You Go today.

EyeMed Vision Benefits

Answers to Common Vision Benefit Questions

How do I use my benefits?

Simply find a doctor, schedule an appointment and receive services. We'll handle all the paperwork, when you visit an in-network provider.

Can I view my EyeMed benefits online?

Yes, you can view your benefits and do a lot more on our secure Member Web – such as print an ID card, check the status of a claim, locate a provider and download an Explanation of Benefits.

Want on-the-go access?

Download our mobile app (App Store or Google Play) to get the same features, plus the ability to save a vision prescription and set an eye exam reminder.

How do I submit a claim?

We take care of all of the paperwork when you visit an in-network provider.

If you see an out-of-network provider AND you have out-of-network benefits as part of your vision benefits package, you'll need to pay at the time of service and complete a claim form to send to us for reimbursement. Be sure to include an itemized paid receipt with your name.

Will I get an ID card? How do I order replacements or extra cards?

Yes, we provide 2 ID cards in the subscriber's name, but you aren't required to have it at the time of service. If you lose your card or need extras for your family, you can print a replacement by creating an account at eyemed.com or downloading the EyeMed Members App (App Store or Google Play) to pull up a digital version anytime, anywhere.

How do I find an eye doctor in your network?

Simply visit our enhanced provider search on eyemed.com or the mobile app to choose from thousands of in-network providers. You can filter your search by your frame preferences, hours of operation and much more – and then even schedule your appointment.*

Does EyeMed offer any additional discounts?

We sure do! At participating in-network providers, members can receive 40% off additional complete pairs of glasses or 20% off a partial pair (lenses only or frames only). You can also receive 20% off non-prescription sunglasses and accessories. If that's not enough, you can create an account at eyemed.com and login anytime to view special offers.

Don't like wearing glasses or contacts? We also offer discounts on LASIK laser vision correction. To find a LASIK provider, visit eyemedlasik.com or call 1-877-5LASER6.

I don't see any or all of my dependents on Member Web. Why?

Due to privacy guidelines, we only show family members who are under the age of 18 under the subscriber. Anyone 18 or older will need to register for his or her own account.

Does EyeMed sell individual insurance plans?

Yes, visit http://individual.eyemed.com to see if an individual plan is offered in your state.

*At select in-network providers

EyeMed Vision Benefits

Answers to Common Vision Benefit Questions, *continued*

Can I use my benefits online?

Absolutely! You can use your in-network benefits to purchase contact lenses and eyewear online at:

LensCrafters lenscrafters.com | Target Optical targetoptical.com | Ray-Ban ray-ban.com/eyemed | Glasses.com glasses.com | contactsdirect contactsdirect.com

If I have an FSA, can I apply funds to out-of-pocket costs after my EyeMed benefit is applied?

Yes. You can use your Flexible Spending Account (FSA) to pay for a variety of health-related out-of pocket expenses, including those associated with supplementary benefits like vision benefits. Money from the FSA can be applied toward the eye exam copay, out-of-pocket costs for prescription glasses or contact lenses (including upgrades), and supplies such as contact lens solution. Employees can even use FSA funds for LASIK surgery. Vision care out-of-pocket costs are also eligible for Health Savings Account (HSA) reimbursement, although these expenses do not count toward your annual deductible.

I don't wear glasses and can see fine. Why do I need an eye exam?

Getting an eye exam is not just about corrective vision – it's about your health. An eye exam can detect eye health problems like glaucoma or cataracts, as well as help identify signs of diseases that impact your whole body, such as high blood pressure, diabetes and high cholesterol – just to name a few. To learn more about vision wellness, visit eyesiteonwellness.com.

At what age should my child first visit the eye doctor?

The American Optometric Association recommends that your child should have his or her first eye exam with an optometrist or ophthalmologist between 6 months of age and 1 year.1 The doctor may check for nearsightedness, farsightedness, astigmatism, amblyopia (or "lazy eye"), proper eye movement and eye alignment, how the eye reacts to light and darkness, and other eye health problems. They also recommend that your child's next eye exam should take place sometime between the ages of 3 and 5, and then every year after that. During these exams, the doctor will conduct a comprehensive eye exam as well as vision screening tests. To learn more about your child's vision, visit eyesiteonwellness.com.

My child gets a vision screening at school. Is there still a need for an eye exam?

A vision screening does not take the place of an eye exam. Generally, they check a child's ability to see far away and check for color blindness, but a comprehensive eye exam evaluates the entire structure of the eye and also allow the doctor to view nerves and blood vessels, providing a glimpse into a child's overall health. Eye doctors may also check for farsightedness, which is more common in younger children.

How often should I get an eye exam?

As with any type of ongoing health care, annual eye exams are a good rule of thumb unless otherwise directed by your doctor. To learn more about eye exams, visit eyesiteonwellness.com.

Can I get the same care at a retail provider as I can at an independent doctor?

All optometrists, regardless of the setting of their practice, must meet the same state licensing and credentialing requirements. In addition, due to the finite number of optometry schools in the United States, optometrists are trained consistently regardless of the practice model they eventually choose.

EyeMed Vision Benefits

Hearing Discount Pricing Information

$2,800
average MSRP per hearing aid

59%
average savings off MSRP on top-selling hearing aids with EyeMed exclusive discount from Amplifon

We've got eyes and ears on ways to help save you money.

That's why we teamed up with Amplifon, the nation's largest independent hearing discount network, to add affordable hearing care to your vision benefits. What's even better is that members can choose from hearing aid styles by nearly all major manufacturers, including those with the newest, most advanced technology.

	EyeMed Hearing Care Discount Program		
	Premier	**Signature**	**Advantage/Plus**
Amplifon pricing	$2,395 – $2,695	$1,895 – $2,395	$695 – $1,895
MSRP range	$3,895 – $9,579	$2,995 – $9,125	$2,535 - $2,685
Amplifon average savings off MSRP	54%	51%	35%
Technology features	• 10–48 channels • 4–7 memory settings • 360 adaptive directionality • Wireless and Bluetooth	• 8–32 channels • 3–5 memory settings • Multichannel adaptive directionality • Wireless and Bluetooth	• 6–24 channels • 2–4 memory settings • Multichannel adaptive directionality • Wireless and Bluetooth

See — and hear — life to the fullest.

amplifon Hearing Health Care

Short Term Disability Benefits: The Hartford

File a claim with confidence.

The Hartford makes it easy to file a claim.

Step 1: Know when it's time to file a claim.

If you're absent from work, we can advise you on when to file a claim. If your absence is scheduled, such as an upcoming hospital stay, call us 30 days prior to your last day of work. If unscheduled, please call us as soon as possible.

Step 2: Have this information ready.

- Name, address and other key identification information.
- Name of your department and last full day of active work.
- The nature of your claim or leave request.
- Your treating physician's name, address, phone and fax numbers.

Step 3: Make the call or file online.

With your information handy, call The Hartford at 1-866-223-0367. Or file online at **https://abilityadvantage.thehartford.com**. You'll be assisted by caring professionals who'll take your information, answer your questions and file your claim or process your leave request.

Get supportive assistance.

Even after your claim has been filed, we may be in touch to check your progress, answer questions or obtain additional information from you. Our goal is to offer a smooth and hassle-free experience until you return to work. Feel free to also call us with anything that's on your mind. We're here to help.

Relax and stay positive.

You have the assurance of our knowledge, experience and understanding of what you are going through. We're with you all the way, so you can receive the benefits you qualify for and get back to your life.

Abilityadvantage.thehartford.com

To File a Claim:

1-866-223-0367

8am-8pm EST

Policy #: **697812**

https://abilityadvantage.thehartford.com

If you're absent from work, we can advise you on when to file a claim. If your absence is scheduled, such as an upcoming hospital stay, call us 30 days prior to your last day of work. If unscheduled, please call us as soon as possible.

When you call, The Hartford will ask you to provide:

- Name, address and other key identification information.
- Name of your department and last full day of active work.
- The nature of your claim or leave request.
- Your treating physician's name, address, and phone and fax numbers.

The Hartford's goal is to help get you through your time away from work with dignity and assist you in any way we can. We'll be there when you need us.

Life Insurance Information 2023: The Hartford

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

Funeral Concierge

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

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

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

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

Use code: **HFEVLC**

Beneficiary Assist® Counseling

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

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

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

Life Insurance Information 2023: The Hartford, *continued*

Estate Guidance® Will Services

Create a simple will from the convenience of your home.

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

Visit: **www.estateguidance.com**

Use code: **WILLHLF**

Travel Assistance with ID Theft Protection

Even the best planned trips can be full of surprises.

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

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

Call: **800-243-6108**

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

Fax: **202-331-1528**

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

Travel Assistance

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

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

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

What to have ready:

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

abilityadvantage.thehartford.com

Seven Tips for Choosing Your Life Insurance Beneficiary

Selecting who will get your life insurance payment

You've made a great choice to help protect the security of your loved ones with a Life insurance plan from The Hartford. Now, you have another important choice to make: who will be your beneficiary?[1]

A beneficiary is the person or legal entity who receives the Life insurance payment if the insured person dies.[2] An example of a legal entity is a trust fund you may have set up.

To help make your beneficiary decision simpler, turn the page to learn some key things to consider.

Please Remember:

If you don't name a Life insurance beneficiary, your benefits will be paid according to the beneficiary provision in your certificate. See your employer's intranet/internet site for plan details.

1. You can name as many beneficiaries as you want.

Specify whether you want each to be one of the following type:

- Primary beneficiary
- Contingent beneficiary

The contingent beneficiary receives a payment only if there's no primary beneficiary entitled to payment. Just remember to provide each person's full name, his or her relationship to you, and the contact information – including phone number and mailing address.

2. You can designate a trust as a beneficiary.

When the insured person dies, the Life insurance payment can go to the trust as beneficiary.

3. You can decide how you want the beneficiary payment divided.

- Use percentages. Make sure the total adds up to 100 percent.
- You can also choose to have the payment evenly divided among beneficiaries.
- Avoid using dollar amounts since your coverage amount may change.

4. There may be a court process if you designate your estate as a beneficiary.

That process, known as probate, may be used to settle an estate. It will:

- Resolve all claims and distribute property under a valid will;
- Protect the deceased's instructions;
- Confirm who is the personal representative of the estate;
- Protect the interests of family members who may have claims against the estate; and
- Protect the personal representative against claims and lawsuits.

Seven Tips for Choosing Your Life Insurance Beneficiary, *continued*

5. There may be a court process if a minor is a beneficiary.

If the beneficiary is a minor, which is allowed, a court may need to decide who should be the guardian or conservator of the minor's property before payment can be made.

6. Submit your beneficiary designation.

Use the DAYFORCE online portal to set up the beneficiary designation. Contact the Employee Benefits Team for navigation assistance at 1-614-645-8624.

7. Be sure to review your beneficiary choices from time to time.

- Check to see if the decisions you made still fit your plans, especially after major events like a birth, marriage or divorce.
- Beneficiary designations can't be signed or changed by a power of attorney.

If you need help reviewing or changing your beneficiary, contact the Employee Benefits team at **1-614-645-8624**, or email us at **EmployeeBenefitsandWellness@Columbus.gov**

1 You may want to talk to an estate planner, accountant or attorney before you make your decision.

2 A benefit will be payable if the insured person, who must be eligible for coverage under the plan, suffers a covered loss while coverage is inforce. Limitations and exclusions may apply. 4060 NS 11/18

Tools and support for healthier living

Healthy Columbus helps City employees and family members achieve and maintain their health and quality of life. The opportunities to be active are endless!

Real Appeal:
The fast track weight loss program you've been waiting for!

Do you want to learn the secrets that have helped people lose 10, 20, or even 30 pounds or more?

The Real Appeal weight loss program is personalized just for you and fits into your schedule for lasting results, fast! You can get it all without turning your life upside down, without giving up the foods you love.

Real Appeal gives you the tools, the information and the support you need to make smarter choices, day in and day out, to truly transform yourself.

- **Right at your fingertips** - The Real Appeal app gives you access to digital tools any time, anywhere.
- **Ready-to-go coaches** - Meet someone who understands exactly where you're at, and keeps you moving toward your goals: your own personal coach.
- **Made-for-you tools** - Over time, our members have participated in creating a ton of options. Use one, or use them all to craft your own weight loss plan that works.
- **Your people await** - Each member joins a strong circle of friendship and support, connecting in group class as well as your favorite social spaces.

No two people are the same. You'll get personalized, individualized support and professional coaching for a full year, online and on your smart phone – at no cost to you.

Get fast, long lasting, transforming results by signing up today! You'll look better and you'll feel better.

For more information or to enroll in Real Appeal please visit **CityofColumbus.realappeal.com** or call **1-844-344-REAL (7325)**.

Tools and support for healthier living

Quit For Life:
Do you want to quit tobacco?
We can help.

Tobacco use can be addictive, causing multiple chronic illnesses. Quit For Life® can help empower you to overcome tobacco and e-cigarette use through an easy-to-use, clinically proven program.

Get the support you need to quit your way:

The Quit Coach® Team
Having someone to talk to can really help you quit. Our Quit Coaches understand what you're going through. Best of all, they know what works. During a series of phone coaching sessions, they'll help you map out a quit plan and give you quit tips that really work.

Quit Smoking Medications
Nicotine cravings and the urge to smoke make quitting hard. That's why we talk with you about prescription and over-the-counter medications that can help reduce cravings and withdrawal symptoms. We'll help you decide which ones might be right for you. You may even qualify for free nicotine replacement therapy like patches or gum.

Quit Tools
With Quit For Life, you receive powerful print and online tools to help you live tobacco-free.

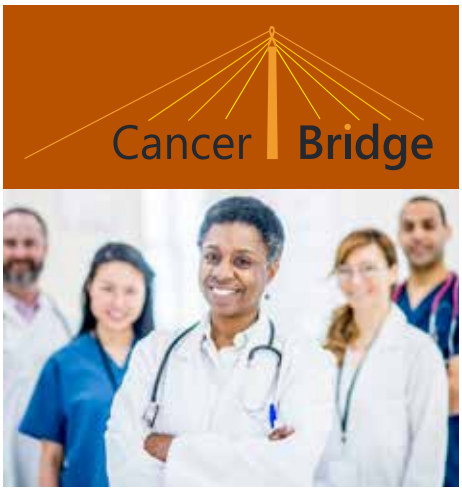
- Use the **Quit Guide workbook** to stay strong between coaching calls.
- Connect with other people trying to quit and track your progress on the members-only website.
- Get **Text2Quit℠ reminders and tips** sent right to your smartphone.

You can enroll in Quit for Life by calling **1-866-QUIT-4-LIFE** (1-866-784-8454) or online at **www.quitnow.net**.

CancerBridge: Connecting you with world-renowned cancer experts

We are pleased to announce that CancerBridge is providing cancer resource services to all members, employees, and their family members in IAFF, HACP, OLC and MCP Ordinance groups.

CancerBridge is available now to provide personalized support programs focused on cancer education, prevention, and the importance of early detection screenings. If you or your family receive a cancer diagnosis, we are here to provide guidance and support throughout the experience by connecting you to cancer experts from a National Cancer Institute designated Comprehensive Cancer Center.



Access:

Employees have access to our:

- Nurse phone line—for cancer-related questions, call 1-855-366-7700 Monday through Friday, 8am–5pm EST
- Virtual Prevention & Wellness Series
- On-site Events
- Cancer Support Program

Benefit Eligibility:

The CancerBridge service is available to all employees and their family members.

Cost:

There will never be a fee for covered employees and their family members to use the CancerBridge service.

CancerBridge has your online guide to cancer prevention, screening and detection, and cancer support.

Our Member Area gives you access to the CancerBridge resource library stocked with featured benefit information, webinars, downloadable resources and recipes. Visit **mycancerbridge.com/member-login** or simply scan the QR code to access our Member Area.

Username: **cityofcolumbus**
Password: **mycancerbridge**

For all benefit-related questions, please email **hello@mycancerbridge.com.**

Front Street Fitness:
The City Employee Fitness Center

The Front Street Fitness Center is managed by OhioHealth fitness experts and offers a healthy experience for people of all fitness levels. Take charge of your health today!

Services and Amenities:

- Cardiovascular equipment, including treadmills, ellipticals, rowers and bikes.
- Strength machines, multipurpose cable towers, smith racks and free weights.
- Access to a multipurpose studio for a variety of in-person and virtual group fitness classes, including:
  - Full-body strength
  - Yoga
  - Zumba
  - Cycling
  - 10-minute break classes
- Locker rooms with towels, shower products, hairdryers, day-use lockers and reserved lockers
- In-person and virtual programs and challenges
- Annual fitness assessments and equipment orientations
- In-Body fitness assessment consultation
- Health coaching*
- Nutrition consultations*
- Personal training*
- Personal program design*

* *Enhanced fitness services are available for a fee, please be on the lookout for incentivized award opportunities to use these services in the future through wellness challenges.*

Front Street Fitness Center

102 N. Front Street (inside the employee parking garage, near Cravings Cafe)
(614) 645-3979
Open 5 a.m. to 8 p.m.,
7 days a week

Take advantage of Virtual and On-DemandFitness Classes and In-Body Fitness Assessments.

Call for an appointment.

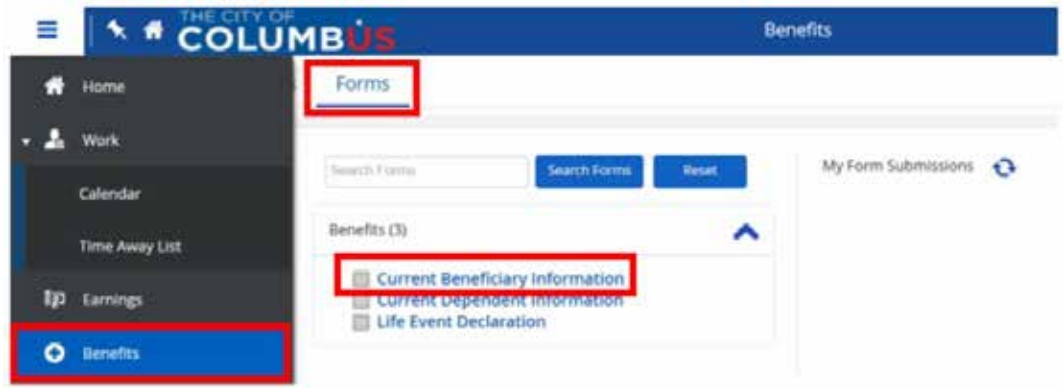
Cost is free! Join today!

Visit: **columbus.gov/hr/healthy-columbus/wellness-program/Front-Street-Fitness/**

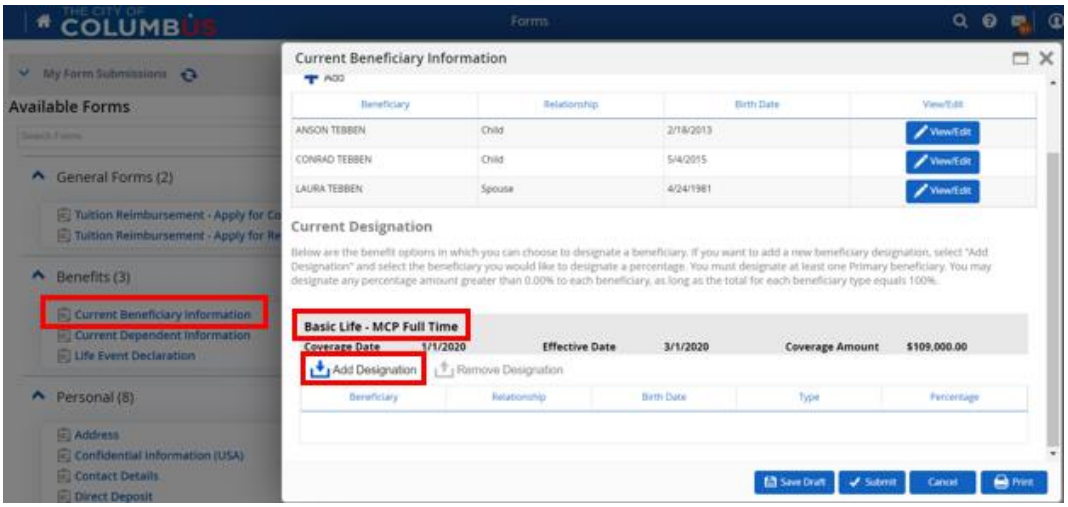
Updating Your Beneficiary Designation in Dayforce

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

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



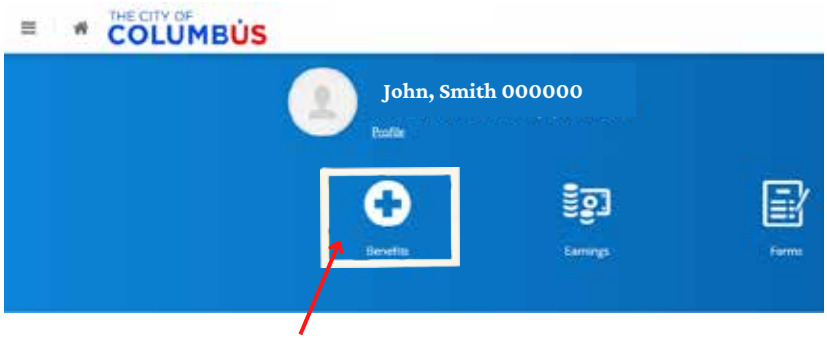
STEP 2. Click on Current Beneficiary Information. Add Designation under Basic Life on the form to add the type and percentage.



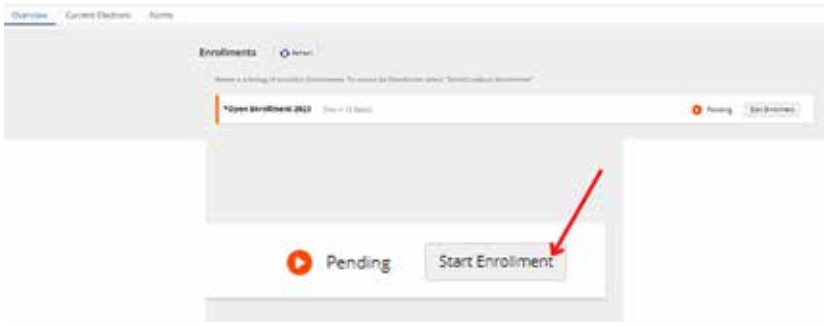
STEP 3. Click Submit.

How to Use Dayforce During Open Enrollment

STEP 1. Enter Dayforce with your login credentials.
User Name is your employee ID number
Initial Password is birth year and last 4-digits of your social security number.
Ex. 19501234
System will ask you to reset your password if this is your first time entering the system.
Once logged into Dayforce, in the blue banner at the top of the screen select the **Benefits** icon in the top menu bar.



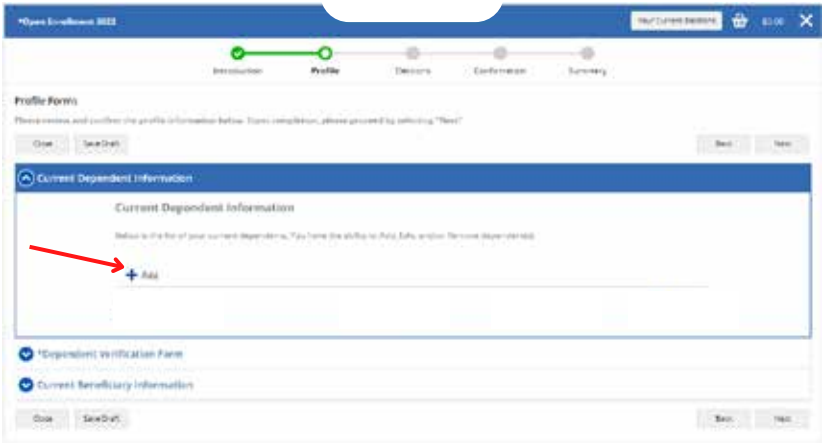
STEP 2. On the Benefit page **Overview** tab you will see a list of all active enrollments. Find the Open Enrollment (year) task. To open and start the enrollment you will click the **Start Enrollment** button to the left of the task.



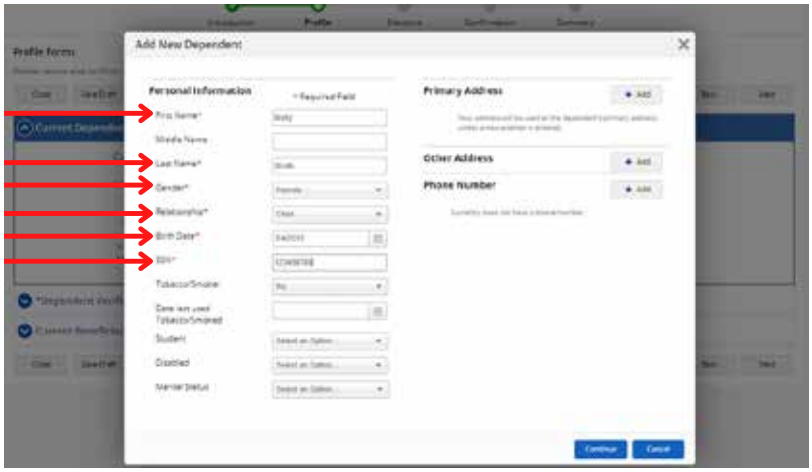
STEP 3. **Review** Open Enrollment Information, Disclosure and Key points. Select **Next**.

How to Use Dayforce During Open Enrollment, *continued*

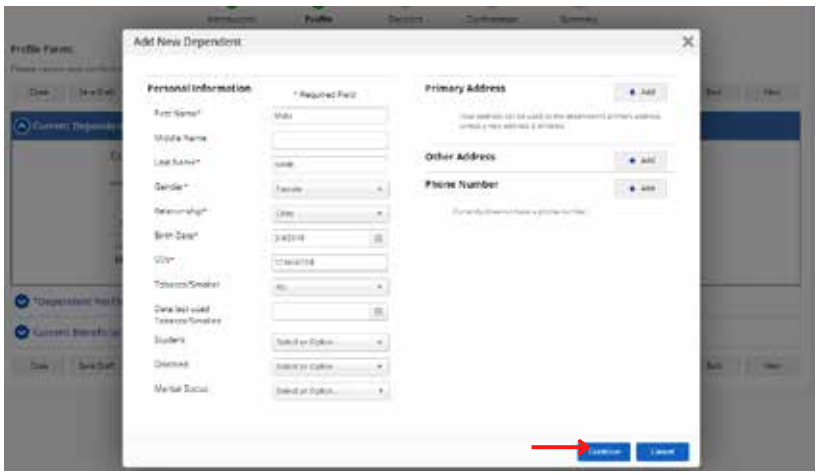
STEP 4. **Review** Current Dependent and Current Beneficiary Information. To add a new dependent, select the **Add** button.



STEP 5. Fill out dependent information. Be sure to fill out all required fields:
First Name, Last Name, Gender, Relationship, Birth Date, Social Security Number.

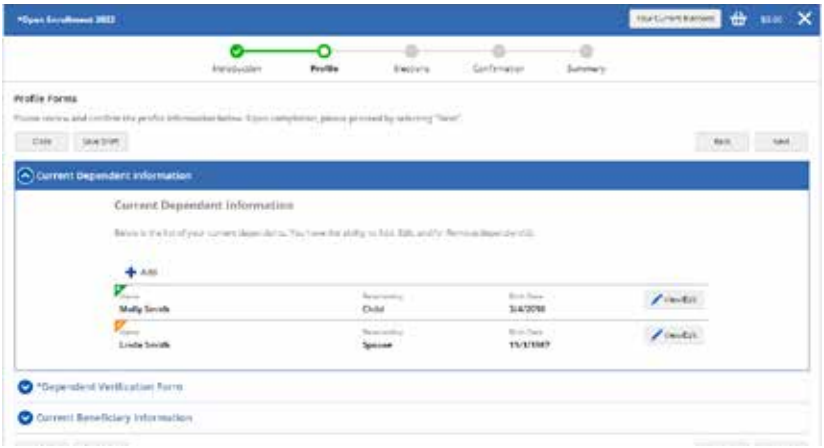


STEP 6. Select **Continue** when done.

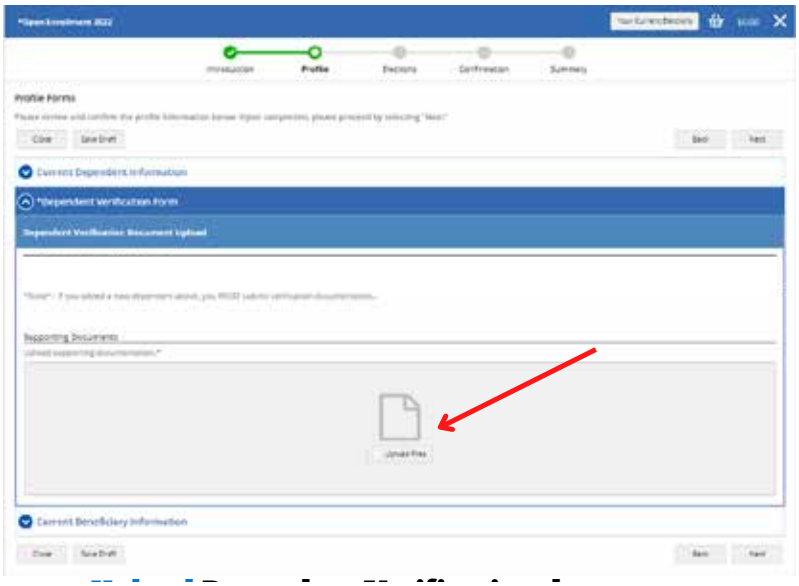


How to Use Dayforce During Open Enrollment, *continued*

STEP 7. You will return back to your Current Dependent information list and will now see all added dependents. Verify all are listed. Repeat previous steps if you need to add multiple dependents.

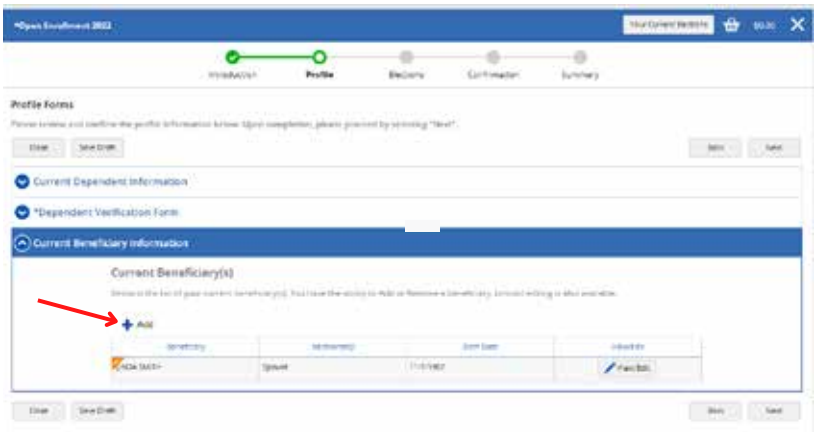


STEP 8. Upload Dependent Verification documents. For full list of acceptable documents see: https://www.columbus.gov/hr/Employee-Benefits/City-of-Columbus-Definitions-and-Required-Documents-Verification-List/

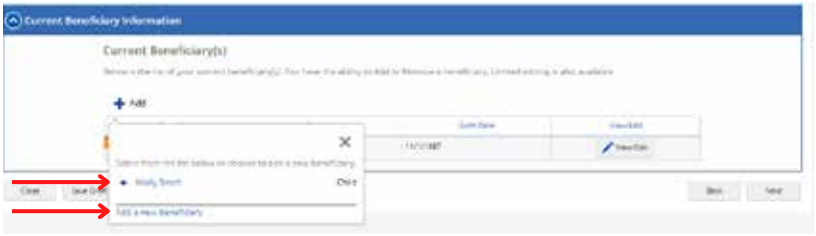


How to Use Dayforce During Open Enrollment, *continued*

STEP 9. To update/add Beneficiary information select the Add button under Current Beneficiary Information.



STEP 10. Select an option from the drop-down menu or select Add to add a new beneficiary.

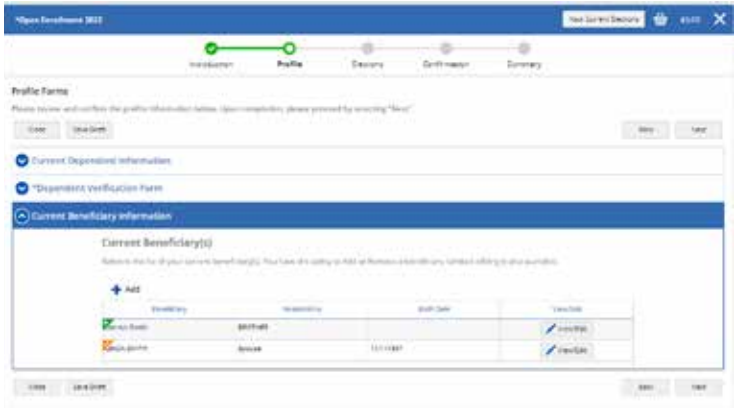


STEP 11. Fill out dependent information. Be sure to fill out all required fields: First Name, Last Name, Relationship.

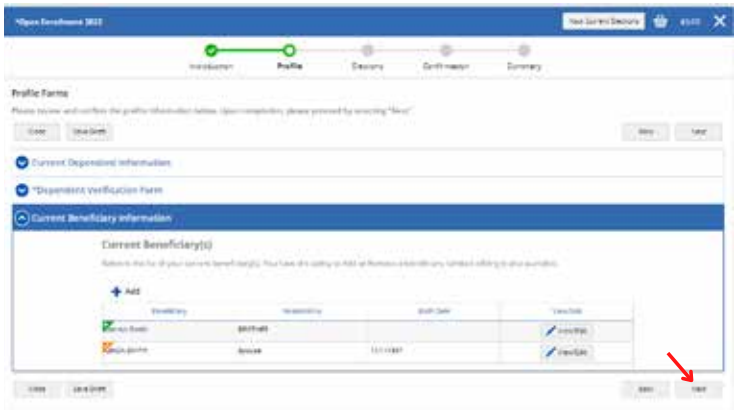
STEP 12. Select Continue when done.

How to Use Dayforce During Open Enrollment, *continued*

STEP 13. You will return back to your Current Beneficiary Information list and will now see all added Beneficiaries. Verify all are listed. Repeat previous steps if you need to add multiple beneficiaries.



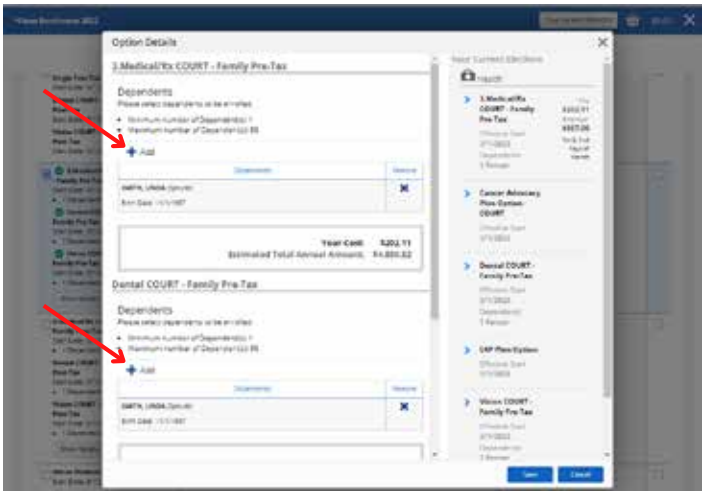
STEP 14. Click Next.



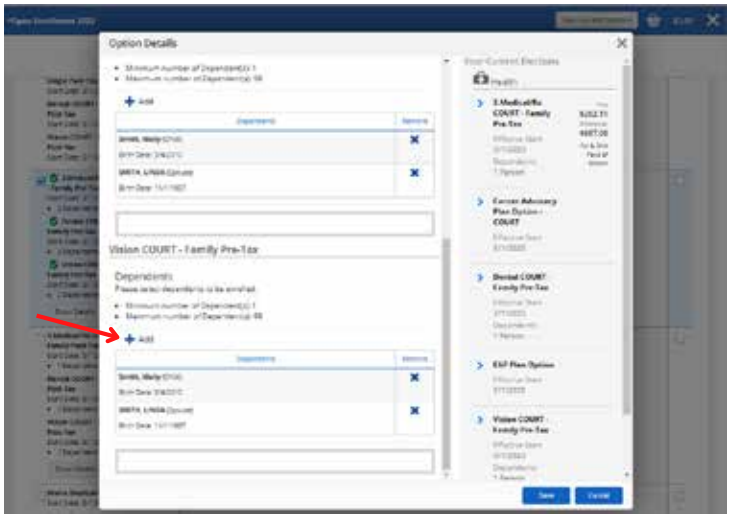
STEP 15. Under the Health section, Checkmark the desired plan option from the list provided. Your current election will be designated with a Green Checkmark. Ensure that you only checkmark one plan option.

How to Use Dayforce During Open Enrollment, *continued*

STEP 16. If Selecting a Family plan, click Show Details to enroll/remove dependent(s)on the plan. Click Add to enroll. Click the next to the name X to remove.

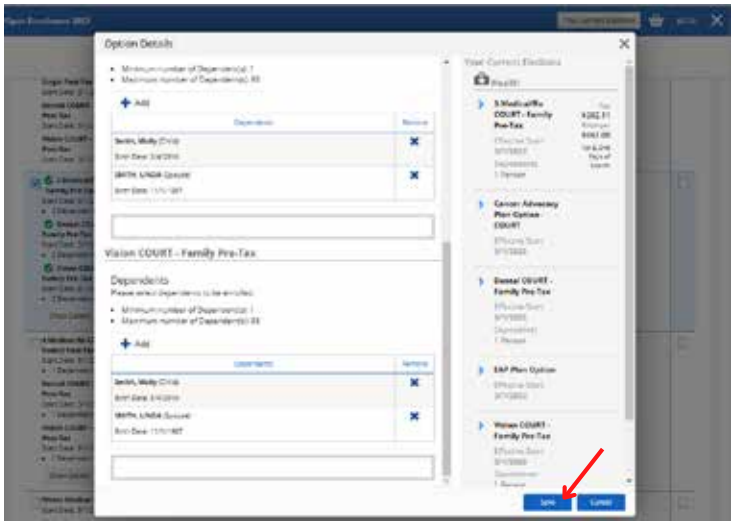


STEP 17. Be sure to scroll all the way down and ensure you add desired dependents under the Medical, Dental and Vision plans.

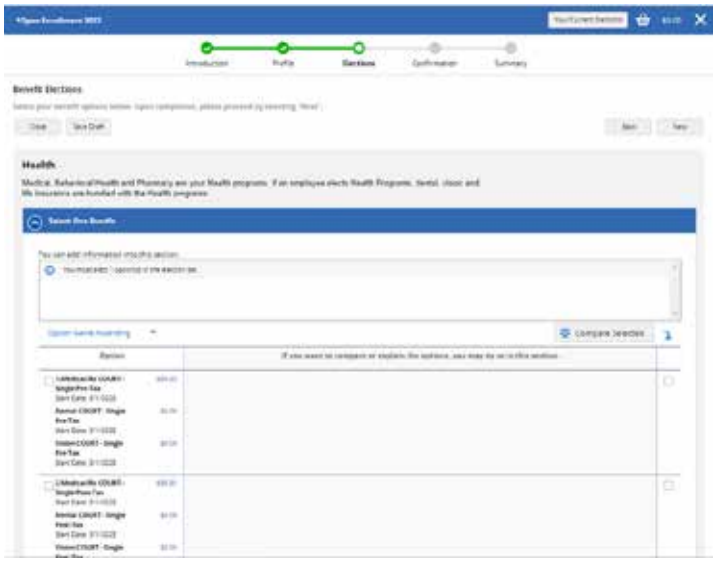


How to Use Dayforce During Open Enrollment, *continued*

STEP 18. Click Save once all desired dependents are added.

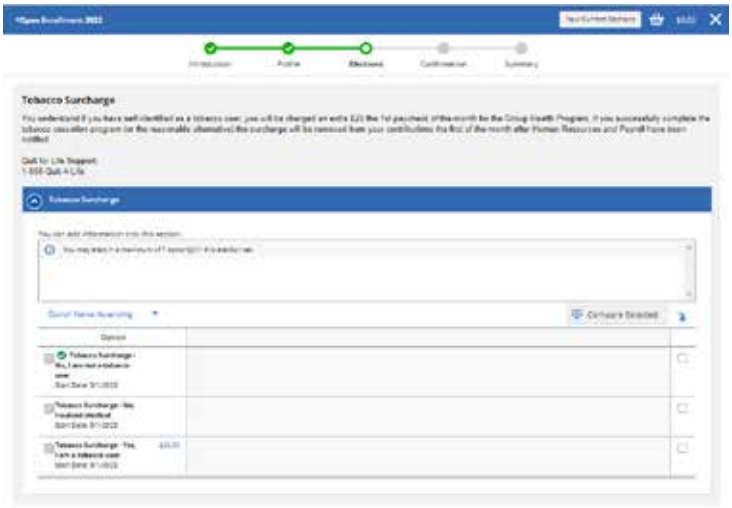


STEP 19. If wanting Single coverage, Checkmark the desired Single plan option from the list provided. Ensure to only checkmark one plan option.

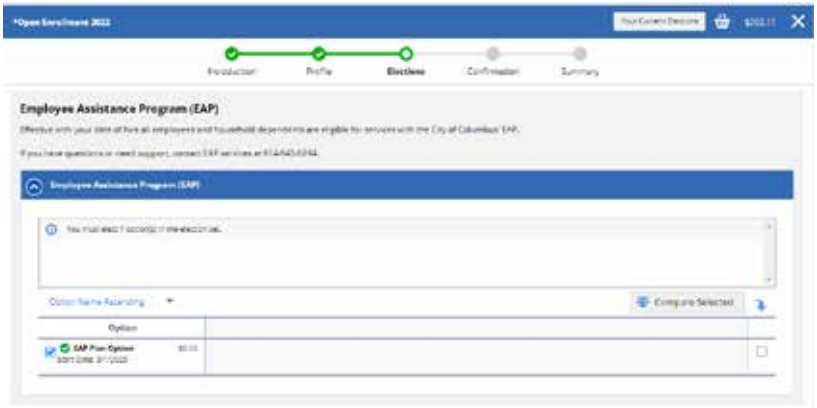


How to Use Dayforce During Open Enrollment, *continued*

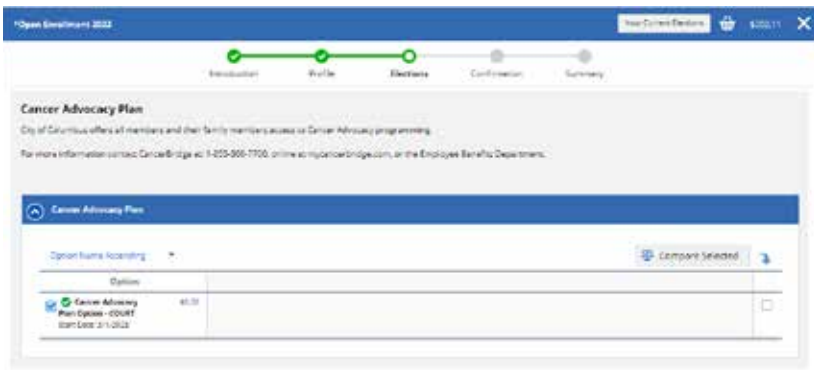
STEP 20. Continue to make your elections, ensure the checkmark for the appropriate Tobacco status is selected if populated.



STEP 21. Continue to make your elections, checkmark the EAP Plan.

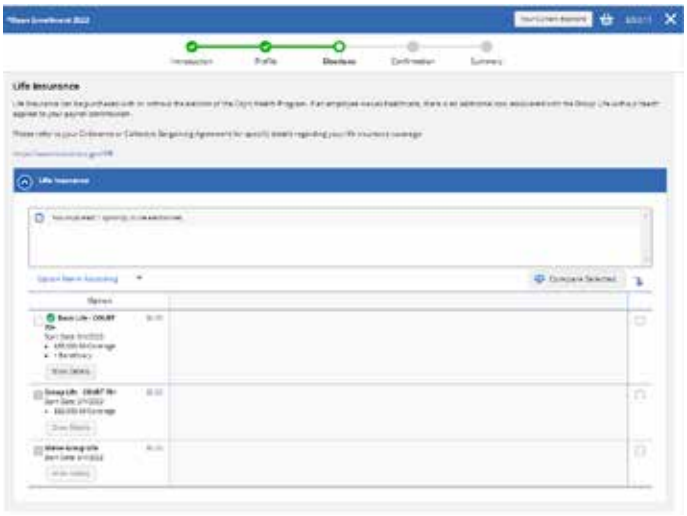


STEP 22. Continue to make your elections, checkmark the Cancer Advocacy Plan, if applicable.

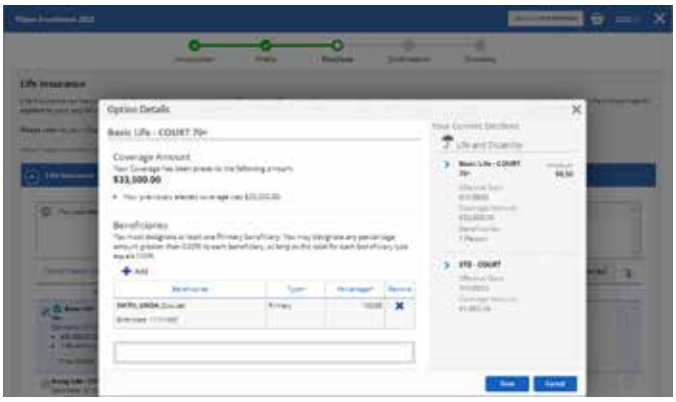


How to Use Dayforce During Open Enrollment, *continued*

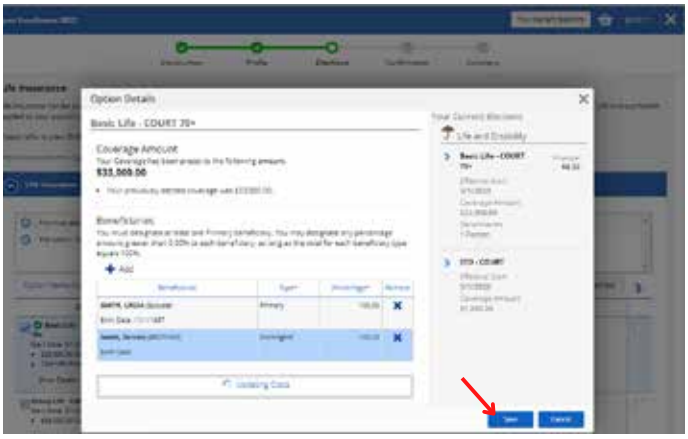
STEP 23. Continue to make your elections, checkmark your desired Life Insurance Plan Option. Your unavailable option(s) will be greyed out.



STEP 24. To add beneficiaries to your life insurance, select Add and select the beneficiary you would like to include. Ensure the name shows up under the Beneficiaries box. Select The Type as Primary or Contingent and the desired percentage designation.

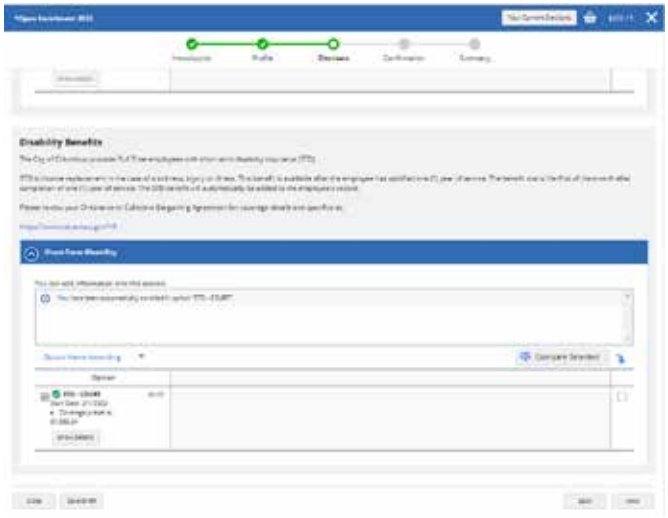


STEP 25. Ensure all Primary beneficiaries add up to 100% and all Contingent beneficiaries add up to 100%. Click Save.

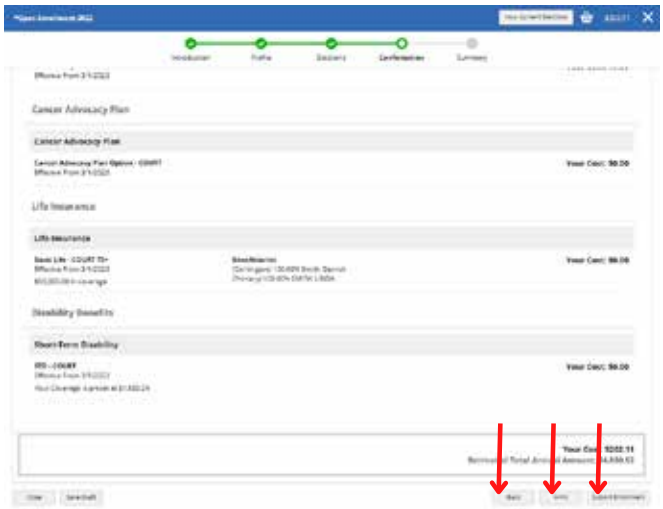


How to Use Dayforce During Open Enrollment, *continued*

STEP 26. Continue to make your elections, ensure the checkmark for the STD plan option is selected if populated. When completed, click Next, if applicable.



STEP 27. Verify the elections you have made match your intended enrollment. If you need to make a change click Back. You can print a copy of you selection by selecting Print. To submit your enrollment click Submit Enrollment.



STEP 28. You have successfully completed your Open Enrollment Task! To close out of the enrollment click Return to Benefits. You may print a copy of your elections by selecting Print.

Required Verification Documents: Adding Dependents

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

The required documents must be uploaded to DAYFORCE during the enrollment event:

New Hire: Within 30 days of your date of hire

Qualified Life Event, i.e. marriage, birth, etc.: Within 30 days of the date of the life event

Open Enrollment: No later than the end of the Open Enrollment period

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

READ THIS ENTIRE VERIFICATION LIST BEFORE YOU ENROLL YOUR DEPENDENTS.

Checklist

- ☐ **Enroll your dependent(s) in the Dayforce system.**
  Refer to Navigation Tip Sheet.
- ☐ **Refer to the dependent types on the following pages.**
  Identify the documents required.
- ☐ **Upload documents in the Dayforce system.**
  Refer to Navigation Tip Sheet.
- ☐ **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:	www.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** **Four (4) 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.	**One (1) of the following OPTIONS:** **OPTION 1:** Covered employee or domestic partner's most recent Federal Income Tax Return (1040, 1040A or 1040EZ) **as filed with the IRS** listing the child as dependent - Page 1 **PLUS** signature page if filed hard copy; **OR** - Page 1 **PLUS** Certificate of Electronic Filing **OPTION 2: Birth Certificate of child** **OR** **If one of the OPTIONS above is not available (i.e., when adding a newborn), one (1) of the following:** - Hospital release papers on hospital letterhead - Footprints - Crib Card - Letter from physician or hospital on respective letterhead
Stepchild (up to age 26)	A natural (biological) child of a covered employee's spouse, i.e. a stepchild of the covered employee	**One (1) of the following OPTIONS:** **OPTION 1:** Covered employee or spouse's most recent Federal Income Tax Return (1040, 1040A or 1040EZ) **as filed with the IRS** listing the 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.	**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:** 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.	**One (1) of the following OPTIONS:** **OPTION 1:** Covered employee or domestic partner's most recent Federal Income Tax Return (1040, 1040A or 1040EZ) **as filed with the IRS** listing the child as dependent - Page 1 **PLUS** signature page if filed hard copy; **OR** - Page 1 **PLUS** Certificate of Electronic Filing **OPTION 2:** Court documents for the adopted child from a court of competent jurisdiction **OPTION 3:** International adoption papers from country of adoption **OPTION 4:** Papers from the adoption agency showing intent to adopt If submitting spouse's tax return, court documents or adoption papers, and the spouse is not covered under the employee's plan, documents proving eligibility of the spouse are also required.
Child (up to age 26) covered by a QMCSO	A child for whom health care coverage is required through a Qualified Medical Child Support Order (QMCSO).	**One (1) of the following OPTIONS:** **OPTION 1:** Court documents signed by a judge **OPTION 2:** Medical support orders issued by a State agency

Disabled Dependent

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

Resources To Obtain Documents

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

Overview and Next Steps

Open Enrollment is January 23rd through February 28th, 2023. Open Enrollment changes requested must be submitted no later than February 28, 2023 in the DAYFORCE Employee Self Service system.

Remember!

Open Enrollment is your annual opportunity to make changes to your healthcare coverage election for the next plan year. Open Enrollment is voluntary for 2023. Your current benefit election will rollover to the next plan year if you do nothing, however we encourage all members to do the following:

- Confirm the correct social security number is on file for all of your eligible dependents. The DAYFORCE system will not accept erroneous or duplicate social security numbers in the system. Coverage for your dependent can be suspended without the correct social security number on file.
- Confirm you have designated your life insurance beneficiary in the system. DAYFORCE does not house those previous paper enrollment records. If you have not done so already, please enter the system and designate beneficiary(ies), their percentage and type as primary or contingent. Please see instructions for navigating the DAYFORCE system.
- Please note, dependents connected with healthcare coverage will always appear on your record. You will simply need to mark them as inactive. DO NOT Overwrite a dependent record. The system will error the entire record and potentially cause delays in coverage activation. If you need assistance removing or adding a dependent call the Benefits Office for assistance.
- **Attention Part Time Employees:** Please re-enroll in coverage annually. The benefit package you are offered may have changed with the last round of contract negotiations and may impact your enrollment eligibility in vision and dental.
- **Life Events:** Cannot be processed during Open Enrollment and will not resume automation until after the beginning of the next plan year, March 1, 2023. Employees must still enter the declaration in DAYFORCE to meet the 30-day window rules and upload verification documentation. We will process the declaration in the normal way and hold the approval in the workflow process. Once we receive the request to approve the life enrollment change, we will do a manual override in the system on behalf of the employee. Benefits will only need to assist in this way for the annual open enrollment period.
- **New Hires:** New Hires starting work during our annual open enrollment period through the end of the plan year (February 28, 2023), will need to complete New Hire Enrollment event in DAYFORCE. If the new hire needs to elect benefits for current plan year, they will 'First' need to complete their New Hire Enrollment Event, and THEN 'Second' the Open Enrollment 2023 event with an effective date of March 1, 2023. Employees with a hire date after February 1st will not see the 2023 Open Enrollment Event. Please contact the Benefits and Wellness office if you require a 2023 Open Enrollment event to be opened for you.

Overview and Next Steps

Next Steps:

- Employees should verify the DAYFORCE address, email and email preferences and telephone number(s) in the system. If you need to update your records, please do so using the “Personal” Forms options.
- If you currently have post-tax healthcare deductions coming from your paycheck, please take this opportunity to update your election to the default pre-tax status for our healthcare plan.
- Remember, all enrollment and change request must be submitted in DAYFORCE no later than February 28, 2023.
- Changes made during open enrollment become effective on March 1, 2023.

Why do I need to make sure my address, email and telephone number(s) are correct?

From time to time, the Benefits and Wellness Office or the companies that administer our programs may need to get in touch with you. In order to do that, the City needs your up-to-date contact information. All employees are encouraged to verify this information.

How do I find out if my healthcare contributions are post-tax?

Log in to the DAYFORCE system, click on Benefits. From the OVERVIEW page, click on Current. Your current coverages and tax deduction status will appear on the summary page.

Why do I need to make sure my dependent(s) are reviewed?

The Benefits and Wellness Office or the companies that administer our programs may need to coordinate benefits and/or produce notifications to our plan members related to plan provisions and services. Our office needs the current information for all dependent(s) enrolled in the Plan.

What if I need more information or have questions about open enrollment?

Go to **http://columbus.gov/HR/Employee-Benefits** for additional 2023 Open Enrollment information and Plan materials. You may also contact the Benefits and Wellness Office at **EmployeeBenefitsAndWellness@columbus.gov** or 614-645-8624, 8 a.m.-5 p.m., Monday through Friday.

Contacts

United Healthcare
1-800-681-3849
www.myuhc.com

Delta Dental
1-800-524-0149
www.deltadentaloh.com

EYEMED Vision Plan
1-866-800-5457
www.eyemed.com
Insight Network

Hartford Life and Disability
1-866-223-0367
Abilityadvantage.thehartford.com

Colonial Life (Supplemental benefits provider)
1-614-745-5963

Open enrollment is here!

Open Enrollment is held from January 23 through the end of February. Outside of open enrollment, you may only enroll or make changes to your insurance coverage within 30 days of a Life or Work event.

THE CITY OF
COLUMBUS
ANDREW J. GINTHER, MAYOR

DEPARTMENT OF
HUMAN RESOURCES

benefits & wellness programs

THE CITY OF
COLUMBUS
ANDREW J. GINTHER, MAYOR