SECTION 16. INSURANCE.

(A) Health Insurance. The City shall provide comprehensive major medical, dental, vision care, and prescription drug benefits for eligible employees in effect at the time of this amendment through December 31, 2017. Effective January 1, 2018, the City shall provide benefits for eligible employees as detailed below, for both the employee and family coverage. Such major medical, dental, vision care and prescription drug benefits will be available beginning the first of the month following the date of hire. Life insurance is effective the first of the month following the date of hire. This coverage shall also comply with all pertinent state and federal statutes, including the Health Insurance Portability and Accountability Act (HIPAA) and the Newborns' and Mothers' Health Protection Act (NMHPA) of 1996.

(B) Comprehensive Major Medical.

(1) If the employee and/or dependent receives services from a preferred provider (PPO), reimbursements will be at an eighty/twenty percent (80/20%) co-insurance and will be subject to single and family deductible and out-of-pocket maximums listed in Table 1.

(2) If a preferred provider is not used, co-insurance will be reduced to sixty/forty percent (60/40%) of one hundred forty percent (140%) of the single and family deductibles and out-of-pocket maximums listed in Table 1.

(3) Physician office visits will be subject to co-payments per in-network primary care physician visits listed in Table 1. Eligible services, which shall include diagnostic, surgical and/or specialty services provided in the network physician's office and billed by that office shall be covered at one hundred percent (100%) after office visit co-payment.

(4) The office co-payment does not apply to the annual deductible, however, office co-payments will apply to the annual out-of-pocket maximum. Care rendered by non-network providers shall be subject to the annual deductible, co-insurance, and out-of-pocket maximum as specified in Section 16(B)(1) and 16(B)(2), and a twenty percent (20%) penalty.

(5) Pursuant to the NMHPA, all inpatient and outpatient treatment for psychiatric and/or alcohol or drug treatment (substance abuse) services will not be subject to treatment limits and will be covered as standard medical treatment. Coverage is subject to deductible, co-insurance, and out-of-pocket maximums.

(6) In-Patient Hospital Coverage. After satisfying the annual deductible, the plan pays eighty percent (80%) of reasonable charges for a semi-private

room and ancillary services for medical stays at an in-network hospital. Once out-of-pocket expenses and reasonable charge provisions have been met, the plan will reimburse the hospital at one hundred percent (100%) for covered services.

For utilization at a non-network hospital, an additional twenty percent (20%) penalty and any excess charges above reasonable rates are the employee's responsibility. Any charges for medically unnecessary care, non-covered services or charges beyond plan limitations are the employee's responsibility.

(7) In accordance with the Patient Protection and Affordable Care Act of 2010, insured members are eligible to receive certain preventive care services, based upon age, gender and other factors, without cost-sharing (co-payments, co-insurance and deductibles). These preventive services must be provided by doctors and health care professionals within the City's plan provider network. The preventive health services that must be covered without cost-sharing requirements are those based on the requirements stated below:

(a) Evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force (USPSTF), including certain preventive care for women, such as mammograms, cervical cancer screenings and prenatal care;

(b) Immunizations for routine use in children, adolescents and adults that are currently recommended by the Centers for Disease Control and Prevention (CDC) and included on the CDC's immunization schedules;

(c) Strong scientific evidence-informed preventive care and screenings for infants, children and adolescents, as provided for in the Health Resources and Services Administration (HRSA) guidelines; and

(d) As noted above, a set of additional scientific evidence-based preventive services for women recommended by the Institute of Medicine and supported by HRSA.

Preventive services that are excluded from the above agencies' recommended lists shall be subject to the annual deductible, co-insurance, and out-of-pocket maximum as specified in Section 16(B)(1) and 16(B)(2).

Preventive services rendered by non-network providers shall be subject to the annual deductible, co-insurance, and out-of-pocket maximum as specified in Table 1.

Insured members should contact the City's health plan administrator prior to obtaining preventive services for determination of preventive services coverage.

(8) An emergency room visit will be subject to a seventy-five-dollar ($75.00) co-payment per visit. If admitted, the co-payment will be waived. An urgent care visit will be subject to a thirty-dollar ($30.00) co-payment per visit.

(9) Miscellaneous benefits with specified limits:

Physical therapy, occupational therapy, and/or chiropractic visits will be covered up to a combined annual maximum for thirty (30) visits per person, based on medical necessity.

Prescription drug deductible charges are not payable under this medical provision.

The City will provide the following minimum coverage for maternity benefits: At least forty-eight (48) hours of inpatient hospital care following a normal vaginal delivery; and at least ninety-six (96) hours of inpatient hospital care following a caesarean section and physician-directed aftercare. These minimum stay requirements are not applicable if the mother and her health care provider mutually agree that the mother and her child may be discharged earlier.

A weight loss schedule is limited to examination charges only. Food supplements in the treatment of obesity are excluded.

Services rendered by a Hospice Care program will be covered up to a maximum of sixty (60) days. Covered services include those services for which an employee is eligible during a hospital admission.

Temporomandibular joint pain dysfunction, syndrome or disease or any related conditions collectively referred to as "TMJ" or "TMD" will be covered on the basis of medical necessity, up to a lifetime maximum of $200.00. This limit does not apply to surgical services on the jaw hinge.

(C) Prescription Drugs. The City will provide a prescription drug coverage plan that provides for the use of a formulary and prior authorization requirements.

(1) CO-PAYMENTS AND OUT-OF-POCKET MAXIMUMS

The employee shall be responsible for a five-dollar ($5.00) co-payment for a Tier 1 drug. For a Tier 2 drug, the co-payment is fifteen dollars ($15.00). For a Tier 3 drug, or if a prescription is written “dispense as written” and a lower tier drug exists, the co-payment is thirty dollars ($30.00). The annual out-of-pocket maximum per single contract per year will be two thousand dollars ($2000.00). The annual out-of-pocket maximum per family contract per year will be four thousand dollars ($4000.00).

Pre-natal vitamins are covered with a written prescription from the physician.

(2) MAIL ORDER

Mail order prescription drugs will be limited to a thirty (30) day minimum and a ninety (90) day maximum supply. The out-of-pocket maximum for prescription drugs filled through mail order will be the same as described in Section 16(C)(1). Under the mail order program, the employee shall be responsible for a twelve dollars and fifty cents ($12.50) co-payment for a Tier 1 drug. For a Tier 2 drug, the co-payment is twenty-five dollars ($25.00). For a Tier 3 drug, or the prescription is written “dispense as written” and a generic equivalent exists, the co-payment is sixty dollars ($60.00).

Maintenance drugs should be obtained through the mail order program. The original prescription with no refills may be purchased locally but subsequent refills must use the mail order program.

The prescription drug program will include prior authorization requirements for certain types of drugs. Some drugs will require the employee and/or dependent to undergo step therapy (trial of a lower cost drug before a higher cost drug is covered). The prescription drug program administrator will determine which drugs require prior authorization and/or step therapy.

(3) SERVICES NOT COVERED

- Experimental drugs.
- Drugs that may be dispensed without prescription.
- Non-prescription items.
- Medications which are covered under the terms of any other employer, sponsored group plan, or for which the individual is entitled to receive reimbursement under Workers’ Compensation or any other Federal, State or Local governmental program.
- Immunization Agents (except as provided in Section 16(B)(7)(b)).
- Drugs deemed not medically necessary.
- Administration of prescription drugs.

- Any prescription refill in excess of the number specified by the physician, or any refill dispensed after one year from date of the physician's original order.
- Medication taken by, or administered to, the individual while a patient is in a licensed hospital, extended care facility, nursing home or similar institution which operates, or allows to be operated, on its premises, a facility for dispensing drugs.
- Anti-obesity drugs.
- Dietary and food supplements.

(4) DISPENSING LIMITATION

Each retail prescription may be filled up to a maximum of a thirty (30) day supply and a maximum of a ninety (90) day supply for mail order.

(5) MISUSE OF PRESCRIPTION DRUG PROGRAM

Control Drug Management Program. The City's prescription drug program administrator will review prescriptions to assess whether abuse of narcotics and similar drugs may be occurring and will follow up with prescribing physicians as appropriate to further evaluate any suspected instances of abuse.

Misuse or abuse of the prescription drug program, verified by the appropriate law enforcement agency, shall result in suspension of the employee's prescription drug card for a period of twelve (12) months. As used herein, verification of misuse or abuse of the prescription drug program occurs when the appropriate law enforcement agency files criminal charges against the employee or dependent, or refers (diverts) the employee or dependent to a counseling and rehabilitation program in lieu of criminal charges. If the employee/dependent is found not guilty, the prescription drug card shall be reinstated.

(D) Dental.

(1) DENTAL ANESTHESIA

Dental general anesthesia administered by the dentist is a covered service. Osseous surgery is not covered under the dental plan, but is payable under the medical plan.

(2) ANNUAL DENTAL MAXIMUM

The maximum amount payable for covered dental expenses, except orthodontics, for one (1) eligible person in one (1) benefit year is fifteen hundred dollars ($1,500.00).

(3) ORTHODONTIC MAXIMUM

The lifetime maximum payable for dependent orthodontia services for any covered child is eighteen hundred-fifty dollars ($1,850.00).

(4) A voluntary dental PPO shall be available to employees which allows voluntary selection of a participating provider which will result in no-balance billing over reasonable charges. All existing co-insurance levels and exclusions continue to apply.

(5) The following preventive dental services are paid at one hundred percent (100%) of the reasonable charge:

(a) Routine oral examinations – twice in any calendar year, January 1 through December 31.

(b) Routine prophylaxis (cleaning of teeth) – twice in any calendar year, January 1 through December 31.

(c) Topical application of fluoride – twice in any calendar year, January 1 through December 31.

(E) Vision. The City shall maintain the current vision care plan for all eligible employees as follows:

(1) Network Doctor Plan

Deductibles:
Eye Examination $5.00
Lenses and Frames $12.50
Deductibles do not apply toward contact lenses.

Wholesale Frame Allowance	Retail Frame Allowance
$41	$135

(2) Non-Network Doctor Plan Reimbursement Schedule

Eye Examination up to	$35.00
Frames up to	$35.00
Lenses:	
Single Vision up to	$35.00
Bifocals up to	$35.00
Trifocals up to	$60.00
Lenticular up to	$90.00

(3) Contact Lenses (pair) in place of all other plan benefits for the benefit period

Cosmetic (elective)	$90.00 plus exam
Necessary	$170.00 plus exam

(F) Life Insurance. The City shall maintain term life insurance in the amount of one and a half times the employee's annual salary in effect at the time of death for all full-time employees less than sixty-five (65) years of age. Full-time employees, sixty-five (65) to seventy (70) years of age shall receive term life insurance in the amount of sixty-five percent (65%) of one and a half times the employee's annual salary in effect at the time of death not to exceed sixty-five thousand dollars ($65,000). Full-time employees seventy (70) years of age and over shall receive term life insurance in the amount of thirty-nine percent (39%) of one and a half times the employee's annual salary in effect at the time of death not to exceed thirty-nine thousand dollars ($39,000).

Employees who have health insurance from other sources may elect to purchase life insurance coverage only, and shall pay a monthly premium of five dollars and fifty cents ($5.50) for such life insurance coverage. Employees are eligible to purchase additional life insurance through a program established by the Department of Human Resources. Upon termination, employees would be eligible to continue life insurance coverage at the market rate at their own expense.

(G) Eligibility. Eligibility for enrolling new employees for health insurance, dental insurance, vision care, prescription drug and term life insurance shall be based upon an employee's active service in a position or employment, which is to be performed in accordance with an established scheduled working time, such schedule to be based upon not less than forty (40) hours per seven (7) consecutive calendar days for fifty-two (52) consecutive seven (7) day periods per annum unless otherwise required by Federal Law or Regulations. Employees shall become eligible for the benefits outlined in this Section 16, pursuant to the provisions herein, on the first of the month following their hire date.

(1) Full-time employees may waive coverage in the employee insurance programs during the month of February in each calendar year. Once the waiver is executed, the employee must wait until Open Enrollment Month (February) in a subsequent year to re-enroll in the benefit plans. In the event of a divorce, legal separation, the death of a spouse or the spouse involuntarily loses family coverage through the spouse's employer, the employee may enroll with the City of Columbus insurance program within thirty (30) days of such event.

(2) Part-time regular employees who have worked a minimum of one thousand forty (1,040) hours the previous calendar year shall be eligible for medical and prescription coverage only. The employee's share of the

cost of the medical and prescription insurance will be one-half of the established funding rate established by the Department of Finance and Management. The employee's share will be converted into a single and family premium. An open enrollment will be held during the month of February of each year for employee enrollment. In the event of a divorce, legal separation, the death of a spouse, or the spouse involuntarily loses family coverage through the spouse's employer, the eligible employee may enroll with the City of Columbus insurance program within thirty (30) days of such event. Upon the completion of two (2) consecutive years and a minimum of two thousand eighty (2,080) hours, and every consecutive year thereafter, employees' eligible dependents are eligible to enroll for medical and prescription coverage during Open Enrollment Month.

For purposes of this paragraph (G)(2), "hours" counted toward part-time eligibility will include hours worked, Paid Time Off, Personal Business Day, Injury Leave, Workers' Compensation, Military Leave, and FMLA.

(H) Premium Co-Payment. Effective April 1, 2017, the monthly premium is an amount equal to fifteen percent (15%) of the insurance base for single and family coverage. Effective April 1, 2018, the monthly premium will be an amount equal to sixteen percent (16%) of the funding rate established by the actuary for the City for single and family coverage. Effective April 1, 2019, the monthly premium will be an amount equal to seventeen percent (17%) of the funding rate established by the actuary for the City for single and family coverage. For all employees hired on or after October 1, 2017, the monthly premium shall be an amount equal to twenty percent (20%) of the funding rate established by the actuary for the City for single and family coverage.

Such premiums shall be paid through an automatic payroll deduction. Half of the monthly premium will be deducted each pay period not to exceed the total monthly premium.

Providing an employee continues monthly premium coverage payments, insurance coverage for which an employee is eligible will be extended ninety (90) days beyond the end of the month during which an employee's approved leave without pay or leave of absence status became effective. The employee's insurance will then be terminated with an option to participate in the City's insurance continuation program, COBRA, at the employee's expense.

Employees on disability leave, or employees receiving payments in lieu of wages from the Ohio Bureau of Workers' Compensation, must keep their premium co-payments current. If at the conclusion of the ninety (90) day period as specified in the previous paragraph, the premium co-payments are not current, an employee's insurance will then be terminated with an option to participate in the City's insurance continuation program, COBRA, at the employee's expense.

(I) Tobacco Surcharge. If an employee hired on or after October 1, 2017 who participates in the City's insurance program uses tobacco, the employee will be charged a twenty-five dollar ($25.00) per month surcharge.

(J) Pre-Tax Insurance Premiums. Employees are eligible to pre-tax insurance premiums through the City's Pre-tax Plan Administrator.

The City will continue to maintain an IRC Section 125 Plan whereby employees will be able to pay for their share of health and hospitalization insurance premiums with pre-tax earnings. This plan will remain in effect so long as it continues to be permitted by the Internal Revenue Code. Such premiums shall be paid through an automatic payroll deduction.

(K) Voluntary Pre-Paid Legal Services Plan. The City may afford employees the opportunity to participate in a voluntary pre-paid legal services plan payable through payroll deduction.

(L) Appeal Process. The extent of coverage under the insurance policies (including self-insured plans) shall be governed by the terms and conditions set forth in said policies or plans. Any questions or disputes concerning an employee's claim for benefits under said insurance policies or plans shall be resolved in accordance with the terms and conditions set forth in said policies or plans, including the claims appeal process available through the insurance company or third party administrator. In the event the employee benefit booklet and this Ordinance are not specific, the plan administrator's administrative guidelines will prevail; provided, however, that this shall not prejudice the right of the employee to appeal a claim dispute to the plan administrator and to the Ohio Department of Insurance.

(M) Table 1.

Table 1	
Deductible	
In-Network	$300 single / $600 family
Non-Network	$800 single / $1,600 family
Co-insurance	
In-Network	80% / 20%
Non-Network	60% / 40%
Out-of-Pocket Maximum	
In-Network	$700 single / $1,200 family
Non-Network	$1,600 single / $3,200 family
Office Visit Co-pay	
Primary Care	$20 co-pay
Specialist	$30 co-pay
Hospital Inpatient Stay	
In-Network	20% after deductible
Non-Network	40% after deductible
Outpatient Surgery	
In-Network	20% after deductible
Non-Network	40% after deductible
Emergency Room Co-pay	
In-Network	$75 co-pay, 20% after co-pay and deductible (co-pay waived if admitted)
Non-Network	same as in-network
Urgent Care Co-pay	
In-Network	$30 co-pay, 20% after co-pay and deductible
Non-Network	$30 co-pay, 40% after co-pay and deductible
Lifetime Maximum	No maximum
Pre-Notification Penalty	Benefits reduced to **50%** of eligible expenses
Rx Co-pays	Retail/Mail
Tier 1	$5/$12.50
Tier 2	$15/$25
Tier 3/ Dispense as Written	$30/$60
Rx Co-pays Accumulate	Yes
Rx OOP Max	$2,000 single/ $4,000 family
Tobacco Surcharge	$25.00 monthly for new hires as of October 1, 2017