SECTION 8. INSURANCES.

(A) Hospitalization, Surgical, Major Medical, and Prescription Drug. The City shall provide hospitalization, surgical, major medical, physician's services coverage and prescription drug coverage for eligible members. The City shall continue to pay all premiums for single and family coverage, except as provided in Subsection (K) of this Section 7. All current benefit levels shall be maintained with the following changes:

(1) Effective January 1, 2014, 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 (copayments, coinsurance 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 evidence-based preventive services for women recommended by the Institute of Medicine and supported by the 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.

~~Preventive services rendered by non-network providers shall be subject to the annual deductible, co-insurance, and out-of-pocket maximum, and twenty percent (20%) penalty.~~

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

(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) Prescription Drug.~~

~~(1) Under the prescription drug ID card program, a $5.00 deductible will apply to generic prescription drugs or $10.00 for brand name drugs if no generic substitution is available. Brand name drugs, if a generic substitute is available, will be an additional deductible of $25.00, unless deemed medically necessary.~~

~~(2) The dispensing amount will be limited to a thirty-four (34) day supply or one hundred (100) doses whichever is greater.~~

~~(3) Mail order prescription drugs will be limited to a thirty (30) day minimum and a ninety (90) day maximum. Under the mail order program, a $10.00 deductible will apply to generic drugs or $20.00 for brand name drugs if no generic substitution is available. If the prescription is for a brand-name drug, or the prescription is written "dispense as written" and a generic equivalent exists, the co-pay is $50.00.~~

~~(4) A prescription drug preferred provider organization (PPO) arrangement will be offered which allows payment of generic prescription drugs or brand name if no generic substitution is available, under the program benefit levels for participating pharmacies.~~

~~The employee shall be responsible for a five dollar ($5.00) co-pay for a generic drug. If there is no generic drug equivalent for the prescribed~~

~~drug, the co-pay is ten dollars ($10.00). If the prescription is for a brand name drug, or the prescription is written "dispense as written" and a generic equivalent exists, the co-pay is twenty-five ($25.00) for participating pharmacies. If participating pharmacies are not used, an additional ten dollar ($10.00) co-pay shall be imposed.~~

~~(5) Maintenance drugs must 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.~~

~~(6) Misuse of Prescription Drug Program. Misuse or abuse of the prescription drug program may result in the suspension of the employee's prescription drug card privileges for the abusing employee or dependent for a period of twelve (12) months.~~

~~As used herein, misuse or abuse of the prescription drug program occurs when the employee or dependent pleads guilty or is found guilty in a court of competent jurisdiction of a criminal charge relating to the misuse or abuse of prescription drugs or that the employee or dependents are referred to or diverted to a drug treatment rehabilitation program in lieu of a criminal conviction.~~

~~It shall be mutually understood that when an employee's or dependent's privileges are suspended for the misuse or abuse of the prescription card drug program, the benefits of the program shall continue for any other family members determined not to be involved in the misuse or the abuse of the program, through the direct reimbursement program.~~

~~(7) Prescription drug deductible/co-payment charges are not payable under the medical contract.~~

(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) Cost Containment.~~

~~Medical Utilization Review:~~

~~(1) Pre-admission Certification.~~

~~If an employee or a dependent is informed that a non-emergency inpatient admission is necessary, the admission must be pre-certified by the City's Medical Utilization Review Administrator. If no precertification was made or the hospitalization was determined not to be medically necessary, a ten percent (10%) coinsurance will be applied, in addition to the deductible and coinsurance provisions. This ten percent (10%) coinsurance will apply to the out-of-pocket maximum. In the event the care is determined to be medically unnecessary, the employee will be responsible for all charges of medically unnecessary care.~~

~~(2) Assigned Length of Stay.~~

~~Once an elective admission has been pre-certified, a length of stay is assigned. If the hospital stay extends beyond the assigned length of stay, all charges for the additional days of stay will be subject to a ten percent (10%) coinsurance, in addition to the deductible and coinsurance provisions. This ten percent (10%) coinsurance will apply to the out-of-pocket maximum. Medically necessary care will constitute justification for certification of a length of stay extension by the Medical Utilization Review Administrator.~~

~~(3) Continued Treatment and Technological Review.~~

~~Certain outpatient non-emergency therapy, outpatient continued treatment, and advanced technological treatments recommended by an employee's attending physician will require the City's Medical Utilization Review Administrator's approval. These treatments will include:~~

~~I. Therapy~~

~~A. Physical Therapy~~
~~B. Occupational Therapy~~

~~II. Advanced Technological Procedures~~

~~A. Magnetic Resonance Imaging (MRI)~~
~~B. Lithotripsy~~
~~C. Ultrasound Imaging during pregnancy~~
~~D. Angioplasty~~

~~III. Treatment~~

~~A. Chiropractic~~
~~B. Podiatric~~

~~Once a physician informs the employee that it is medically necessary to receive physical therapy, occupational therapy, chiropractic treatment or podiatric treatment on an ongoing basis, the employee must contact the City's Medical Utilization Review Administrator to obtain continued treatment authorization. Also, if the physician instructs the employee to receive any of the listed advanced technological procedures, it is necessary for the member to contact the City's Medical Utilization Review Administrator to obtain pre-treatment authorization.~~

~~In the event the employee does not obtain authorization for continued therapy, treatment, or technological review, the employee will be responsible for ten percent (10%) of the total charges, in addition to the employee's deductible, co-payment and out-of-pocket maximum provisions. In the event the care received is determined to be medically unnecessary, the employee will be responsible for all medically unnecessary care.~~

~~(4) Planned Discharge Program.~~

~~In the event a member or dependent is hospitalized and it is determined that hospitalization is no longer needed, this program allows the patient to receive care in the most medically appropriate setting.~~

~~(5) Mandatory Second Surgical Opinion.~~

~~For all inpatient and outpatient non-emergency surgeries, a second surgical opinion may be required as directed by the Medical Utilization Review Administrator. The second opinion shall be covered at one hundred percent (100%) of the reasonable charges. If the first two opinions conflict, a third opinion shall also be covered at one hundred percent (100%) of reasonable charges. If a second opinion is not obtained for the surgeries, a ten percent (10%) coinsurance shall be applied, in addition to the deductible and coinsurance provisions. This ten percent (10%) coinsurance will apply to the out-of-pocket maximum.~~

~~Based on medical information obtained prior to the surgery, the City's Medical Utilization Review Administrator may waive the mandatory second surgical opinion requirement in specific cases.~~

~~(6) Medical Case Management.~~

~~This program allows a consultant to review a patient's medical treatment plan to determine whether the covered person qualifies for alternate medical care. The determination of eligibility for patient's medical case management will be primarily based upon medical necessity and appropriate medical care. Recommendations will be made to the family and health care providers. The Medical Utilization Review Administrator will recommend alternate medical treatment on a case-by-case basis. Alternate medical treatment benefits refer to expenses that are payable as covered expenses under the medical plan.~~

(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) Vision Care Plan. The City shall maintain the current no-deductible vision care plan for all eligible employees:~~

~~(1) Non-Panel Reimbursement Schedule:~~

~~Professional Fees~~	
~~Examination up to~~	~~$ 35.00~~
~~Materials~~	
~~Single Vision Lenses, up to~~	~~$ 35.00~~
~~Bifocal Lenses, up to~~	~~$ 50.00~~
~~Trifocal Lenses, up to~~	~~$ 60.00~~
~~Lenticular Lenses, up to~~	~~$ 90.00~~
~~Frames, up to~~	~~$ 35.00~~
~~Contact Lenses necessary~~	~~$170.00~~
~~cosmetic (for spouse and dependents only)~~	~~$ 90.00~~
~~cosmetic (for employees only)~~	~~$150.00~~

~~(2) Panel Retail Frame Allowance is $135.00.~~

(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) Dental Care Plan. The City shall maintain the current dental coverage for all eligible employees, including maximum dental care of one thousand five hundred dollars ($1,500.00) per person, per year; and orthodontics of one thousand eight hundred fifty dollars ($1,850.00) coverage.~~

~~In addition, a voluntary dental PPO shall be available to employees that allows voluntary selection of a participating provider that will result in no balance billing over reasonable charges. All existing co-insurances levels and exclusions continue to apply.~~

(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 provide a life insurance benefit of one times annual salary to all employees who die while employed with the City.

~~(G) Personal Liability Insurance. The City agrees to furnish, at no cost to employees, liability insurance for the purpose of insuring employees from liability for errors or omissions committed in the performance of their duties as City employees. In the alternative, the City shall self-insure this benefit.~~

(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) New Employee Eligibility. Employees shall be eligible for hospitalization, surgical, major medical and physician's services benefits, prescription drugs, and life insurance on the first of the month following their date of hire. Such employees shall be eligible for vision care, dental care, and physical examination benefits on the first of the month following a period of ninety (90) days of employment.~~

(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) Physical Examinations. The City shall maintain the current physical examination coverage except that a stress test will not be payable under the physical examination benefit unless deemed medically necessary. The sole exception to this limitation on the stress test will be the first clearing examination for authorization to participate in the physical fitness program as outlined in the Public Safety Department policy, where the employee's physician determines a stress test is necessary to provide medical authorization to participate. If a stress test is deemed medically necessary or provided pursuant to a physician's initial authorization to participate in the physical fitness program, the City will pay eighty percent (80%) of the stress test and stress test interpretation up to a maximum of $250.00 in charges.~~

~~If a mammogram and pap smear are done independent of the annual physical, they will not be counted against the annual physical benefit.~~

(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) Communicable Disease Testing. At no charge to the employee, the Division shall contract with a twenty-four (24) hour medical facility to test employees who may have been exposed to communicable diseases, chemicals, noxious fumes, and/or smoke while in the performance of their duties.~~

(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) Premium Contribution. Employees will be charged a monthly premium for participating in the City's insurance program that shall be paid through an automatic payroll deduction. The monthly insurance premium shall be an amount equal to eleven and one-half percent (11.5%) of the insurance base for single and family coverage. Effective April 1, 2014 the monthly insurance premium shall be an amount equal to twelve percent (12%) of the insurance base. Effective April 1, 2015 the monthly insurance premium shall be an amount equal to twelve and one-half percent (12.5%) of the insurance base. Effective April 1, 2016 the monthly insurance premium shall be an amount equal to thirteen percent (13%) of the insurance base. Effective April 1, 2017 the monthly insurance premium shall be an amount equal to fifteen percent (15%) of the insurance base. Effective April 1, 2018 the monthly insurance premium shall be an amount equal to sixteen percent (16%) of the insurance base. Effective April 1, 2019 the monthly insurance premium shall be an amount equal to seventeen percent (17%) of the insurance base.~~

~~The insurance base shall be the total actual cost to the City of the claims and administrative fees for medical, dental, vision, and prescription drugs for the preceding benefit year of February 1 through January 31. Half of the monthly premium will be deducted each payperiod not to exceed the total monthly premium.~~

(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) Pre-Tax Benefits. A voluntary pre-tax dependent care and pre-tax insurance premium program offered by the City of Columbus or its appointed administrator will continue to be offered. Subsequent enrollments will be offered to new employees at the time of hire; existing employees may enroll during open enrollment month each year.~~

~~Insurance premiums: Each participant who elects to pre-tax the monthly insurance premium must complete the necessary election form which authorizes the City payroll to pre-tax that premium.~~

~~Dependent care program: Each participating employee who elects to enroll in the dependent care program will determine an amount to be pre-taxed biweekly~~

~~through payroll deduction. The annual pre-tax limit, determined by each participant, shall not conflict with IRS limits identified in the Internal Revenue Code.~~

~~Amendments to the annual pre-tax maximum can only occur during open enrollment month, on the annual plan renewal date, or when a change in status occurs.~~

~~Participants will submit allowable claims to the City's plan administrator. Remittance from the participant's dependent care account will be sent directly to each plan participant. Amounts for which a participant does not have an eligible claim will be forfeited.~~

~~These pre-tax plans will remain in effect so long as they continue to be authorized by the Internal Revenue Code.~~

(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.

Police MCP

(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