BENEFITS GUIDE

2025

columbusindiana
unexpected.unforgettable.

ENROLL HERE:

https://cityofcolumbusin.munisselfservice.com/ess/employees/EmployeeSetup/benefits/Default.aspx

Trouble Logging into ESS? Email (Tyler Help Desk) help@cocmunis.on.spiceworks.com

For questions about benefits, please email Human Resources at benefits@columbus.in.gov

WE ARE HAPPY TO PROVIDE YOU AND YOUR FAMILY WITH ONE OF THE MOST COMPREHENSIVE EMPLOYEE BENEFIT PLANS. OUR BENEFITS PROGRAM PROVIDES A VARIETY OF PLANS FOR YOU AND YOUR FAMILY.

THE PLAN YEAR IS

January 1st – December 31st

The City of Columbus is happy to continue to offer excellent, low-cost benefits options to our team members beginning January 1, 2025. The City of Columbus strives to provide you and your family members with comprehensive and valuable benefits. This year's benefits guide has been expanded to include a more complete view of what is available to you.

The 2024 Open Enrollment period will be from October 28, 2024 through November 8, 2024. Please take the time to review all benefits and enroll in coverages that help you and your family.

The elections you make during your Open Enrollment will become effective on January 1, 2025.

WHO PAYS

Benefits Offered	Our Plan Pays	You Pay	Find it on Page
Medical	X	X	8
Preventive Care	X	X	13
Prescription	Included with Medical Coverage	X	17
Health Savings Account (HSA)	The City of Columbus will contribute to eligible accounts annually: **$1,000 Employee Only / $1,500 Family**	**Optional**; The City's minimum deduction for an HSA is $5 per pay up to the max.	19
	Available for members enrolled in the High Deductible Health Plan only.		
Flexible Spending Account (FSA)	Availability to City of Columbus team members varies.	X	26
Health Clinic	X	X	27
Dental	X	X	30
Vision	X	X	31
Short-Term Disability (STD)	X	X	32
Long-Term Disability (LTD)	X	X	32
Life Insurance	X	X	33
Employee Assistance Program (EAP)	X	X	34

Who Is Eligible?

If you are a full-time employee at City of Columbus, you are eligible to enroll in the benefits outlined in this guide. Full-time employees are those who work 30 or more hours per week & **are classified as full-time**.

Working Spouse Rule

The purpose of the Working Spouse Rule is to share costs of medical with other plans or insurance carriers.

1. If an eligible Employee's spouse qualifies for medical coverage through their employer that spouse is not eligible for medical coverage through the City of Columbus.
2. If the spouse is employed with a company that does not offer medical coverage, they may be enrolled in this Plan as their primary plan at the qualifying rate. (If the spouse is employed, a statement from their employer verifying that they have no coverage available will be required.) *
   *Note: Medicare does not count as an employer-sponsored plan for the purposes of this rule.

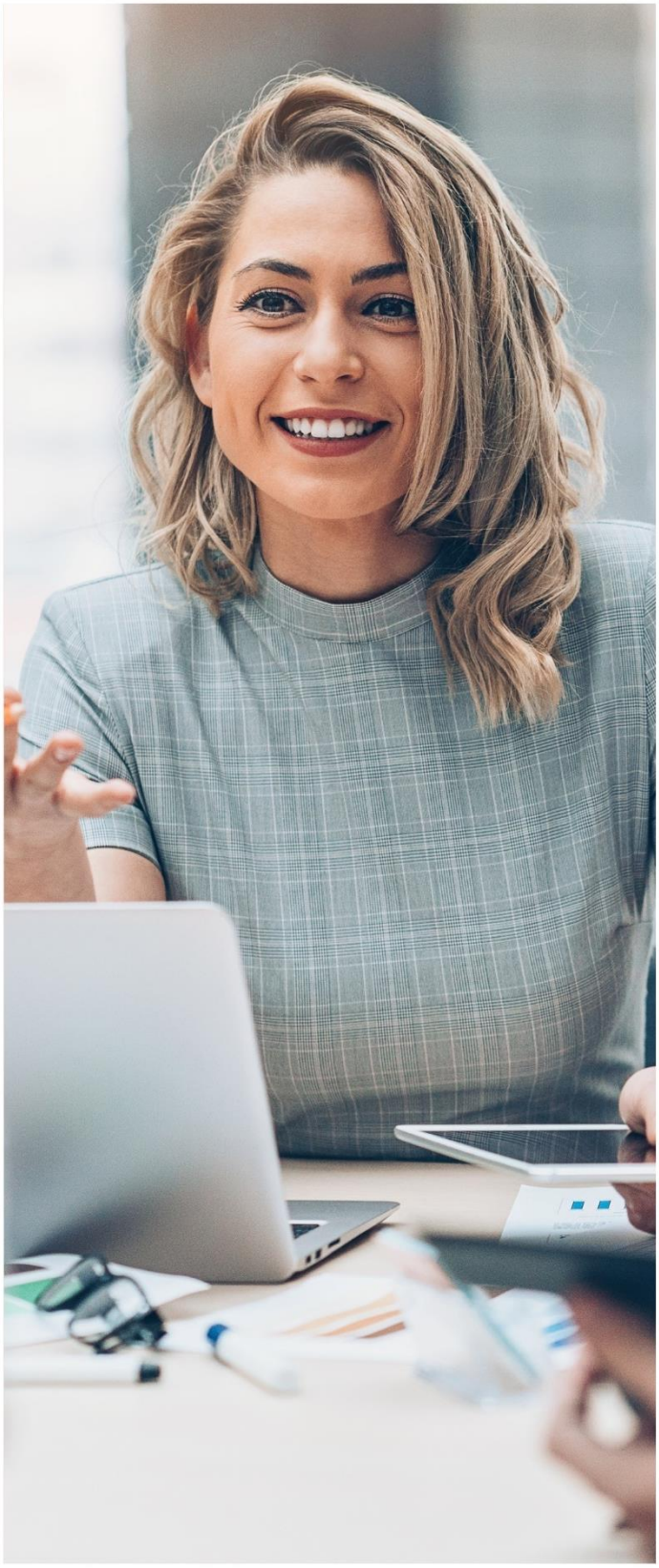
How to Enroll

The first step is to review your current benefits and verify that all of your personal information is correct or make any necessary changes.

How to Make Changes

It is important to make informed choices with your benefit selections at Open Enrollment. Changing coverage during the year is limited to Qualifying Life Events as defined by IRS code Section 125. The IRS rules do not allow for enrollment, additions, changes, or cancellations to most plans without a Qualifying Life Event.

Qualifying Life Event changes must be submitted within **61 days** of the event. Changes to your health, dental, vision and/or FSA must be submitted through the Employee Self Services (ESS) online system. To make a mid-year change, you must certify your change in status or other event, as applicable, and provide eligibility documentation by requesting a Life Event in ESS. ESS can be found at https://ess.columbus.in.gov/ess



Qualifying Life Event

Common Qualifying Life Events are:

- Birth, adoption, or the placement of a child for adoption
- Death of a covered dependent
- Marriage
- Divorce
- Issuance of a court order or decree requiring coverage for a dependent child
- Spouse loss of coverage

Please call or email Human Resources at (812)376-2570 or humanresources@columbus.in.gov if you have any questions about a Qualifying Event.

Coverage	Medical /Dental/ Vision	Flexible Spending Account	Dependent Care Account	Voluntary Life	Dependent Life	Health Savings Account	Document needed
Marriage	Drop or add coverage	Add/Increase /Decrease/ drop coverage (signature required)	Add / increase coverage	No Change	Add/Increase /Decrease/ drop coverage (signature required)	Add/Increase /Decrease/ drop coverage (signature required)	Marriage License
Divorce/Legal Separation	Drop or add coverage	Add/Increase /Decrease/ drop coverage (signature required)	Add/Increase /Decrease/ drop coverage (signature required)	No Change	Add/Increase /Decrease/ drop coverage (signature required)	Add/Increase /Decrease/ drop coverage (signature required)	Final Divorce Decree signed by Judge
Birth/Adoption/Legal Guardianship	Add dependents	Add/increase coverage	Add / increase coverage	No Change	Add/Increase /Decrease/ drop coverage (signature required)	Add/Increase /Decrease/ drop coverage (signature required)	Final legal document signed by Judge

Understanding Qualifying Life Events, Automatic Enrollment, and Health Insurance

Automatic Enrollment: Keeps you covered, but it's better to update and shop 2025 insurance options

The City's Plan moved to Automatic Enrollment in 2024. This means when you enroll, if you fail to make choices in your enrollment then your 2024 elections will still apply. It is always better to update and shop for your insurance. **Open Enrollment for 2025 will begin on October 28, 2024 and end on November 8, 2024.** Be sure to renew, change, update, or cancel your health insurance at the end of 2024. Automatic enrollment is a good fallback, but the best way to make sure you have a 2025 plan that works for you is to view all of your plan options for 2025, and update your elections as appropriate.

Qualifying Life Events

To accommodate unexpected changes in life, submitting a Qualifying Life Event through ESS will ensure that employees can make Plan changes outside of the Open Enrollment period. Your provider gives you the opportunity to make changes to your health insurance plan within 30 days (up to 61 days for childbirth) after a Qualifying Life Event. **To determine your eligibility, notify the Human Resources Department as soon as these circumstances happen.**

What Documents Do I Need for a Qualifying Life Event?

Birth certificates, adoption records, and marriage certificates to show you have added family members and need to modify your coverage. For childbirth or adoption, please do not wait until you get the final paperwork. Please notify the Benefits Specialist when, or before, the child is born. Additionally, documents such as divorce decrees and death certificates may show that family members who provided health insurance have left you without coverage. There are many situations that may constitute a Qualifying Life Event. If you are unsure if your specific circumstances qualify, please speak to the Human Resources Department to determine eligibility and necessary documentation.

Some events may not be considered a Qualifying Life Event. For example, for those who need medical coverage and qualify, Medicaid accepts applications year-round. Additionally, some specialized health insurance plans are designed to provide coverage during changing life situations. These plans provide comprehensive coverage and are not restricted by enrollment periods. Qualifying events for insurance are not always clearly defined, which is why the City's Benefits Specialist and SIHO Member Services can help you understand if your life event changes your health insurance options.

WHAT DOES THAT WORD EVEN MEAN?

We admit it, benefits can be hard to understand. Here are some common benefit words and their definitions to help you as you read through this guide.

AMOUNT BILLED: The amount the Provider billed for your claim before adjustments, copays, deductible, or any ineligible amount.

ANNUAL DEDUCTIBLE: The amount you are required to pay per calendar year before certain benefits are paid for by the plan. Once you meet the deductible amount, expenses are covered by the plan based on the coinsurance percentage. This deductible starts over every January 1st.

ANNUAL OUT-OF-POCKET MAXIMUM: The most you pay in a calendar year for covered services that are subject to coinsurance/copays. The deductible is included in this amount. If you reach the annual out-of-pocket maximum, the plan pays 100% of covered in-network eligible expenses for the remainder of the plan year. Office visits and prescription copays are included in the annual out-of-pocket maximum for our medical plans. This maximum starts over every January 1st.

BALANCE BILLING: When you are billed for the difference between the provider's actual charge & the amount reimbursed under the medical or dental plan. This occurs when you go outside of the preferred provider network. Balance billing does not apply towards out-of-pocket maximum.

COINSURANCE: The percentage you pay for covered expenses.

COPAYMENTS OR COPAYS: The flat dollar amount you pay for certain in-network services.

EXPLANATION OF BENEFITS (EOB): Provides information about how your claim was processed by the insurance company. The EOB details what portion of the claim was paid by the insurance company & what portion is your responsibility.

FLEX (ALSO CALLED FSA): Pre-tax dollars taken from your wages, contributed to a group account administered by EBC (a flex administrator), from which you can pay for your healthcare premiums, certain medications, provider visits, over-the-counter medications, etc., including dependent care. The tax benefits of this account save you money, as you are using pre-tax dollars. The IRS requires that employees "use it or lose it"- they must use all Flex dollars in the year they are deducted, except for a $570 carry-over, so plan accordingly, and know that when you retire/resign, you must submit your expenses from before the date of retirement/resignation (you can't take these dollars with you).

HEALTH SAVINGS ACCOUNT (HSA): A special, tax-advantaged, interest-bearing account to help plan & pay for qualified health care expenses (including plan deductible) while covered by a qualified high deductible health plan (HDHP).

HIGH DEDUCTIBLE HEALTH PLAN (HDHP): A health insurance plan with a sizable deductible for medical expenses but charges lower monthly premiums. Plans fully cover routine preventive care, which means that individuals aren't responsible for copays or coinsurance for what meets the legal definition of preventive care. Employees who choose HDHP are able to open a Health Savings Account (HSA) that employees can keep/take with them even if they leave city employment.

IN-NETWORK: A group of doctors, hospitals and other providers that contract with a plan vendor to provide quality services at favorable rates. The City of Columbus, Indiana offers INSPIRE coverage (lowest cost to members) and In-Network coverage.

PREFERRED PROVIDER ORGANIZATION (PPO): A healthcare arrangement designed to provide healthcare services at a discounted cost for members to use designated providers (the network), but which also provides coverage (at a lower level) for services received from providers that are not part of the network. The City of Columbus, Indiana offers INSPIRE coverage (lowest cost to members) & In-Network coverage.

USUAL, CUSTOMARY, AND REASONABLE (UCR) CHARGES: UCR charges are determined by your health plan vendor & are based on the range of fees charged by doctors with comparable training and experience for the same or similar service in your area. When you receive in-network care, UCR charges don't apply. You're responsible for amounts over UCR for out-of-network care.

PPO – SIHO

LOW DEDUCTIBLE PLAN

	Option 1 – Preferred Provider Plan (PPO)		
	Inspire Providers	*SIHO Providers*	*Out-ot-Network Providers*
Annual Maximum	Unlimited		
Calendar Year Deductible **Individual** **Family**	**Embedded** $1,250 $2,500	**Embedded** $2,000 $4,000	**Embedded** $2,000 $4,000
Calendar Year Coinsurance **Individual** **Family**	$4,750 $9,500	$7,000 $14,000	$7,000 $14,000
Maximum Out-of-Pocket **Individual** **Family**	$4,750 $9,500	$7,000 $14,000	$7,000 $14,000
	Tier 1 and Tier 2 deductibles and coinsurance cross apply. Copays accumulate toward the maximum out-of-pocket and do not apply to Tier 3 and vice versa		
Hospital Room, Services, Supplies, Impatient Surgery, Outpatient surgery	80% after deductible	70% after deductible	60% after deductible
Emergency Room ($150 copay applies if non-emergency)	80% after deductible	70% after deductible	60% after deductible
Urgent Care	80% after deductible	70% after deductible	60% after deductible
Office Visits	80% after deductible	70% after deductible	60% after deductible
2024 Clinic	The City of Columbus is adding a clinic for employees, dependents covered under the insurance, and retirees on the City's retiree insurance.		
Preventive Health Benefit	100% covered-subject to Preventive Health Benefit Guidelines		
Diagnostic X-Ray and Lab	80% after deductible	70% after deductible	60% after deductible
On PPO plan only, labs are covered at 100% at CRH and specified affiliated CRH providers for primary care office visits and outpatient labs.			
Mental Health and Substance Abuse	80% after deductible	70% after deductible	60% after deductible
Physical, Speech & Occ Therapy	80% after deductible	70% after deductible	60% after deductible
Chiropractic Services	80% after deductible	70% after deductible	60% after deductible
	Annual Maximum: 30 Visits		

	EMPLOYEE	EMPLOYEE + SPOUSE	EMPLOYEE + CHILD	FAMILY
Per Pay (26 Pay) Employee Premiums	$74.96	$149.13	$126.40	$171.91
	EMPLOYEE	**EMPLOYEE + 1**	**FAMILY**	
Monthly Retiree Premiums	$624.38	$1,264.54	$1,828.69	

CONTACT SIHO:

800-443-2980

www.siho.org

HSA – SIHO

HIGH DEDUCTIBLE PLAN

Your Plan Features	Option 2 - High Deductible Health Plan (HDHP)		
	Inspire Providers	*SIHO Providers*	*Out-ot-Network Providers*
Annual Maximum	Unlimited		
Calendar Year Deductible Individual Family	**Non-Embedded** $2,000 $4,000	**Non-Embedded** $3,500 $7,000	**Non-Embedded** $3,500 $7,000
Calendar Year Coinsurance Individual Family	$4,750 $9,500	$7,000 $14,000	$7,000 $14,000
Maximum Out-of-Pocket Individual Family	$4,750 $9,500	$7,000 $14,000	$7,000 $14,000
	Tier 1 and Tier 2 deductibles and coinsurance cross apply. Copays accumulate toward the maximum out-of-pocket and do not apply to Tier 3 and vice versa		
Hospital Room, Services, Supplies, Impatient Surgery, Outpatient surgery	80% after deductible	70% after deductible	60% after deductible
Emergency Room ($150 copay applies if non-emergency)	80% after deductible	70% after deductible	60% after deductible
Urgent Care	80% after deductible	70% after deductible	60% after deductible
Office Visits	80% after deductible	70% after deductible	60% after deductible
2023 Wellness Benefit	The City of Columbus is adding a clinic for employees, dependents covered under the insurance, and retirees on the City's retiree insurance.		
Preventive Health Benefit	100% covered-subject to Preventive Health Benefit Guidelines		
Diagnostic X-Ray and Lab	80% after deductible	70% after deductible	60% after deductible
Outpatient Mental Health and Substance Abuse	80% after deductible	70% after deductible	60% after deductible
Physical, Speech & Occ Therapy	80% after deductible	70% after deductible	60% after deductible
Chiropractic Services	80% after deductible	70% after deductible	60% after deductible
	Annual Maximum: 30 Visits		

	EMPLOYEE	EMPLOYEE + SPOUSE	EMPLOYEE + CHILD	FAMILY
Per Pay (26 Pay) Employee Premiums	$49.85	$97.07	$79.52	$114.50

	EMPLOYEE	EMPLOYEE + 1	FAMILY
Monthly Retiree Premiums	$609.50	$1,234.41	$1,770.45

CONTACT SIHO:

800-443-2980

www.siho.org

SIHO PROVIDER TIERS

GET THE MOST BANG FOR YOUR BENEFITS BUCK

Your health plan provides three networks to its members allowing for each member to have a choice in where they seek their healthcare services. The City of Columbus offers a Tier 1 Network composed of providers and facilities that are part of Columbus Regional Hospital and Schneck Medical Center. To take advantage of the highest level of benefits available, you should see providers and receive services at hospitals in the Tier 1 Network.

We understand there may be services for which you need to go outside of the Tier 1 network; therefore, the City of Columbus has partnered with a Tier 2 option for members – the SIHO Network.

And, for those traveling outside of the area, the PCHS network will provide access to a national network for those needs. Services outside Tier 1 or Tier 2 Networks will be paid at Tier 3 benefit levels.

TIER 1 – INSPIRE HEALTH PARTNERS:

• This network will provide the highest level of benefits and should be your first choice for care.
• This network is centered around the goal of keeping members healthy and coordinate patient care so that members can get the most value for their healthcare dollars

- To find a Tier 1 provider go to: https://www.siho.org/provider-directory.html and select the network
- Or Call 800-443-2980 for assistance

TIER 2 – SIHO NETWORK

• When you need to seek care outside of the Inspire Health Partners Network, the plan offers a second network for you to choose from. Benefits may not be as great as in tier 1, but this does provide you with choices to meet your healthcare needs.

- To find a SIHO provider go to: www.siho.org/provider-directory.html and select the SIHO Network
- Call SIHO at 800-443-2980 for assistance

TIER 3 – OUT OF NETWORK – PHCS

• Members may seek services outside of Tier 1 and Tier 2 when outside of the area and in need of health care services.
• Any non-emergent services by providers or facilities outside of the providers in Tier 1 and Tier 2 will be considered Out of Network and paid at Tier 3 benefits.

- To find a PHCS Provider go to: www.siho.org/provider-directory.html and select the MultiPlan Network
- Or Call 888-779-7427 for assistance

DID YOU KNOW?

SIHO INSURANCE SERVICES & INSPIRE HEALTH PARTNERS

UNDERSTANDING THE NETWORK

Your health plan has multiple tiers in order to get healthcare services at the best benefit, you should see providers and receive services at hospitals in the Inspire Network (tier 1).

ABOUT INSPIRE HEALTH PARTNERS

Inspire was created by Columbus Regional Hospital and Schneck Medical Center with the goal to keep members healthy and coordinate patient care, while keeping costs low.

The Inspire name was created as an acronym in which "in" represents both the location of the networks' founding members and clinical providers in **IN**diana, as well as the fact the organization intends to function as a clinically **IN**tegrate network. "**Spire**" is intended to convey both the vision of the organization, to the pinnacle of community-based healthcare, as well as the values that the inspire health network is built upon.

Service to our patients and our communities
Patient-centered
Innovation (value-based)
Results (in regard to continuously moving healthcare forward)
Excellence (in terms of patient experience and clinical outcomes)

WHAT'S BALANCE BILLING?

YOUR RIGHTS & PROTECTIONS AGAINST SURPRISE MEDICAL BILLS

When you get emergency care or get treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from surprise billing or balance billing.

WHAT IS "BALANCE BILLING" (SOMETIMES CALLED "SURPRISE BILLING")?

When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, such as a copayment, coinsurance, and/or a deductible. You may have other costs or have to pay the entire bill if you see a provider or visit a health care facility that isn't in your health plan's network.

"Out-of-network" describes providers and facilities that haven't signed a contract with your health plan. Out-of-network providers may be permitted to bill you for the difference between what your plan agreed to pay and the full amount charged for a service. This is called "balance billing." This amount is likely more than in-network costs for the same service and might not count toward your annual out-of-pocket limit.

"Surprise billing" is an unexpected balance bill. This can happen when you can't control who is involved in your care—like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider.

YOU ARE PROTECTED FROM BALANCE BILLING FOR:

Emergency services

If you have an emergency medical condition and get emergency services from an out-of-network provider or facility, the most the provider or facility may bill you is your plan's in-network cost-sharing amount (such as copayments and coinsurance). You can't be balance billed for these emergency services. This includes services you may get after you're in stable condition, unless you give written consent and give up your protections not to be balanced billed for these post-stabilization services.

Certain services at an in-network hospital or ambulatory surgical center

When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers may bill you is your plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers can't balance bill you and may not ask you to give up your protections not to be balance billed.

If you get other services at these in-network facilities, out-of-network providers can't balance bill you, unless you give written consent and give up your protections.

You're never required to give up your protections from balance billing. You also aren't required to get care out-of-network. You can choose a provider or facility in your plan's network.

WHEN BALANCE BILLING ISN'T ALLOWED, YOU ALSO HAVE THE FOLLOWING PROTECTIONS:

You are only responsible for paying your share of the cost (like the copayments, coinsurance, and deductibles that you would pay if the provider or facility was in-network). Your health plan will pay out-of-network providers and facilities directly.

Your health plan generally must:

- Cover emergency services without requiring you to get approval for services in advance (prior authorization).
- Cover emergency services by out-of-network providers.
- Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits.
- Count any amount you pay for emergency services or out-of-network services toward your deductible and out-of-pocket limit.

Your Preventive Health Benefits

These benefits are fully compliant with the Affordable Care Act (PPACA).

Wellness/Preventive Health Exams

- **Men:** One per year
- **Women:** One per year with family physician, one per year with OB/GYN, if needed

Vaccinations

- **Link to children vaccines:** Birth-18 Years Immunization Schedule – Healthcare Providers | CDC
- **Link to adult vaccines:** Adult Immunization Schedule by Age | CDC

Services for Children

Newborn Screening	As required by state law	Urinalysis	All ages
Iron Screening and Supplementation	All ages	Hematocrit or Hemoglobin Screening	All ages
Visual Acuity Screening	Through age 5	Lead Screening	For children at risk of exposure
Oral Dental Screening	During PHB visit	Latent Tuberculosis Infection Screening	Children determined at risk
Fluoride Supplement	Beginning age 6 months	Dyslipidemia Screening	All ages
PCP Fluoride Application to Primary Teeth	Children through age 5	Depression Screening	Beginning age 12
		Anxiety Screening	Beginning age 8

Children's preventive health visits to include screenings & counseling for: Medical History, BMI & Obesity, Education & Counseling for Prevention of Tobacco Use, Behavioral Assessment, and Skin Cancer Prevention.

Services for Pregnant Women

HIV Screening	1 per pregnancy
Bacteriuria	Lab test
Hepatitis B	Lab test
Iron Deficiency Anemia Screening	Lab test
Gestational Diabetes Screening (any time after 24 weeks)	Lab test
Rh Incompatibility	Lab test
Syphilis, Chlamydia, & Gonorrhea Screening	Lab test
Group B Strep Screening	1 per pregnancy
Healthy Weight & Weight Gain During Pregnancy	Screening & counseling
Breast Feeding Interventions	Counseling, support & supplies
Preeclampsia Screening	Blood pressure monitoring throughout pregnancy
Folic Acid Supplement	Women capable of becoming pregnant
Referral to Counseling	For pregnant & postpartum at risk for perinatal depression
RSV Vaccination	1 per pregnancy
Tdap Vaccination	1 per pregnancy
Aspirin	At risk

Services for All Women

Contraceptive Methods	Covered unless religious exemption applies
Age 21+, HPV DNA testing and/or Cervical Cytology	Every 3 years
Breast Cancer Chemoprevention	At risk
BRCA Risk Assessment and Appropriate Genetic Counseling/Testing	
Screening for Urinary Incontinence	

Adult Procedures and Services	
Bone Mineral Density Screening	Every 2 years age 65 or older **OR** every 2 years less than 65 with risk factors *
Mammogram – including 3D	Baseline – women, once between ages 35-39 ** Yearly for women over 40
Colorectal Cancer Screening – beginning age 45	CT Colonography every 5 years Flexible Sigmoidoscopy every 5 years **OR** every 10 years + FIT every year Colonoscopy Screening every 10 years
Abdominal Aortic Aneurysm Screening	For men who have smoked – one time between ages 65-75
Low Dose Aspirin	At risk initiate treatment ages 50-59
Lung Cancer Screening	At risk – ages 50-80
Statin Preventive Medication	At risk – ages 40-75

Adult Labs	
Lipid Panel	Yearly
Total Serum Cholesterol	Yearly
Comprehensive Metabolic Panel **	Yearly
PSA **	Yearly – men over 50
Highly Sensitive Fecal Occult Blood Testing Or FIT	Yearly – after age 45
sDNA-FIT	Every 1-3 years after age 45
FBG (Fasting Blood Glucose) / OGTT (Oral Glucose Tolerance Test)	Yearly
Hgb A1C	2 per year
HIV Testing	Yearly age 15 to 65 – age range may deviate based on risk
Syphilis Screening	At risk
Chlamydia Infection Screening	Yearly – all ages
Gonorrhea Screening	Yearly – all ages
Hepatitis B & Hepatitis C Screenings	Yearly
Urinalysis **	Yearly
Latent Tuberculosis Infection Screening	At risk

***** Letter of Medical Necessity required

****** Added by SIHO QIC committee, deviates from ACA requirements

All adolescent and adult preventive health visits to include screenings and counseling for:	
Healthy diet and physical exercise – includes referral to behavioral health	Intimate partner violence for men and women
Obesity – includes intensive behavioral interventions for BMI > 30	Blood pressure
Skin cancer prevention	Sexually transmitted infections
HIV infection pre-exposure prophylaxis	Depression / Anxiety
Tobacco and/or nicotine use and FDA approved medication (as indicated)	Developmental / Behavioral assessment / Autism
Unhealthy drug use – medical and nonmedical	Risk for falls
Unhealthy alcohol use	

The **Preventive Health Benefit Guidelines** are developed and periodically reviewed by our Quality Improvement Committee, a group of local physicians and health care providers. The QIC reviews recommendations and guidance from the U.S. Preventive Services Task Force, the Advisory Committee on Immunization Practices (ACIP) of the Center for Disease Control (CDC), and the Health Resources and Services Administration (HRSA). The QIC providers may also offer guidance based on relevant guidance from American Academy of Family Practice Standards, American College of OB/GYN Standards, American Cancer Society Recommendations, and American Academy of Pediatric Standards.

These recommendations were combined with input from local physicians, and the standard Preventive Health Benefit was developed. These standards and recommendations are reviewed biannually, and the benefits are updated in accordance with the Affordable Care Act (ACA) requirements.

Please note that your physician may recommend additional tests or screenings that are not included in this benefit. You may be financially responsible for routine screenings not listed in this brochure.

A screening procedure performed when there is a family history or personal history of a condition (and which does not fall within the listed age or frequency criteria of the Preventive Health Benefit) will be covered under the major medical benefit.

Effective 07/01/2024

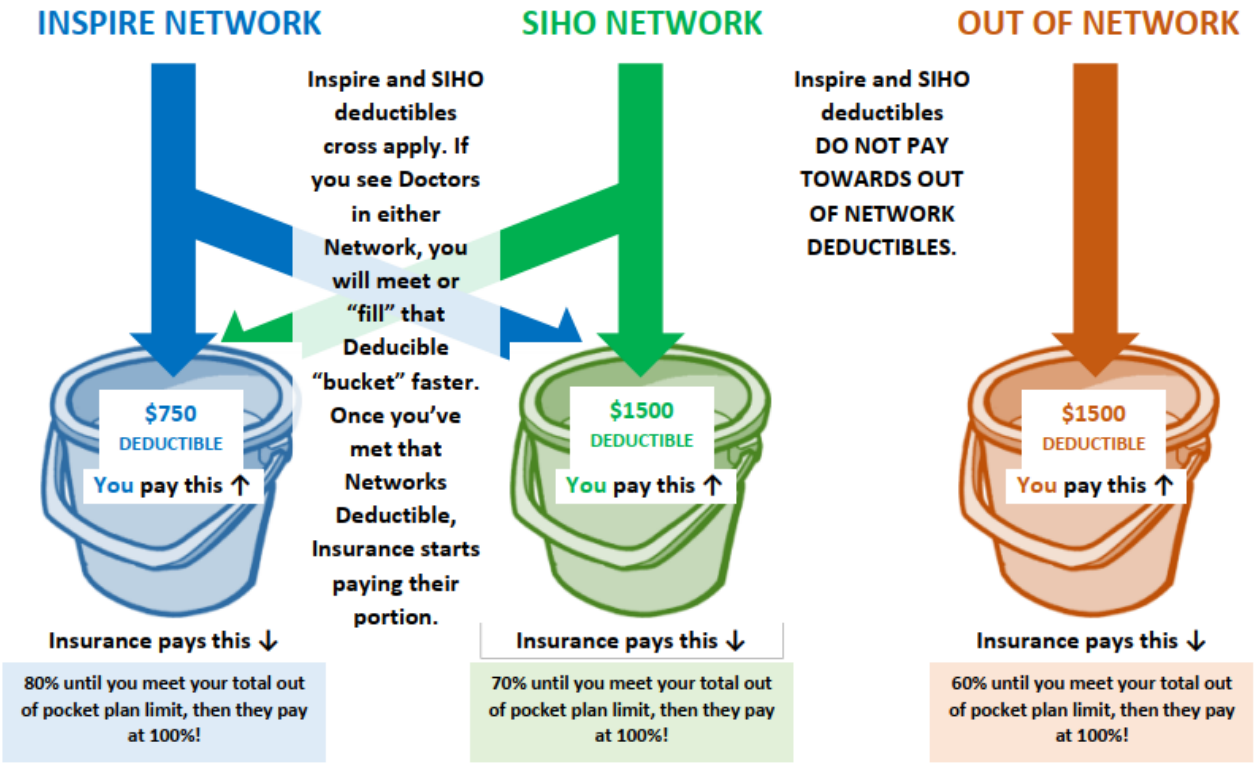
SIHO Insurance Services

Standard Pre-Certification List:

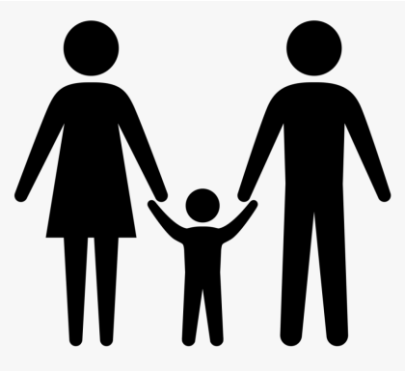
- Inpatient hospital admissions – medical and surgical
- Long Term Acute Care Hospital (LTACH) admissions
- Skilled Nursing Facility admissions
- Inpatient Rehab Facility admissions
- Inpatient Mental Health and/or Substance Abuse admissions – Hospital
- Residential Mental Health and/or Substance Abuse admissions
- Intensive Outpatient Therapy Programs
- Partial Hospitalization Therapy Programs
- Home Health care services – including nursing/PT/OT/infusion
- Hospice
- Oncology – Chemotherapy and Radiation
- Durable Medical Equipment – all rentals, any purchases greater than $1000, includes prosthetics
- Specialty Medications
- Speech Therapy
- Applied Behavioral Analysis (ABA Therapy) – if a covered benefit
- Dialysis
- Genetic Testing – if a covered benefit
- Neurological implants and implanted nerve stimulator devices - including but not limited to spinal cord stimulators and vagal nerve stimulators (VNS)
- Services and treatments related to gender reassignment – if a covered benefit
- Transplant services

SIHO INSURANCE SERVICES

PPO INDIVIDUAL PLAN OPTION EXAMPLE



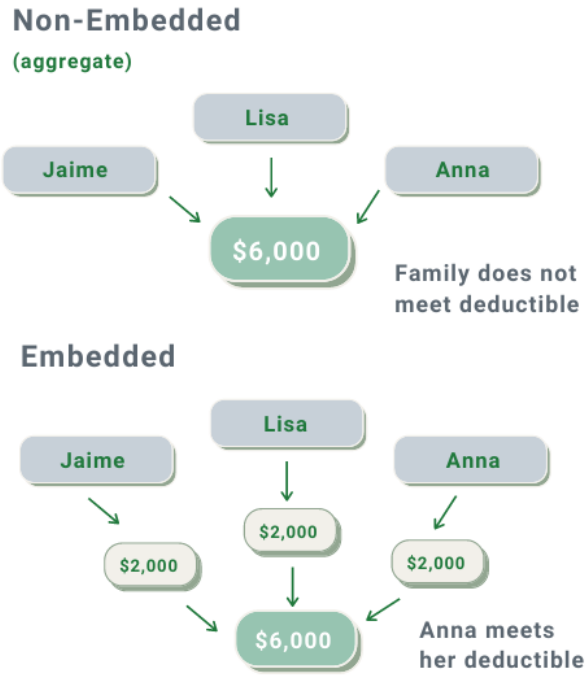
Embedded vs. Non-Embedded Plan Example



Gomez Family: $6,000 Deductible

Medical Bills this year:

- Jaime $500
- Lisa $250
- Anna $5,000



Summary of Prescription Drug Coverage

Your Plan Features*	Option 1 – Preferred Provider Plan		Option 2 – High Deductible Health Plan	
	Retail Service (30-day supply)	**Mail Order Service (90-day supply)**	**Retail Service (30-day supply)**	**Mail Order Service (90-day supply)**
Generic	$10	$25	20% after deductible	20% after deductible
Brand	$30	$60	20% after deductible	20% after deductible
Non-Formulary Brand	$50	$120	20% after deductible	20% after deductible

*Prescription Drugs listed on the High Deductible Health Plan Health Savings Account Preventive Therapy Drug list will be covered at the appropriate coinsurance and not subject to the annual deductible. This list is typically published in January.

An important part of any medical plan is prescription drug coverage. You receive coverage for both generic and brand name drugs, but you pay less for brand name drugs that are a part of the plan's formulary, or preferred drug list. The plan's formulary drugs are chosen by the plan based on their quality, safety, and cost-effectiveness.

You also have the option to take advantage of the Mail Order Service program. By using the mail order program, you can receive 90 days of medication for less than the cost of three 30-day prescription fills at a retail pharmacy. This saves you time and money.

For questions on your prescription coverage, please contact Optum at:
www.optumrx.com / Toll Free: 855-524-0381

Register now

To set up your online account:

1. Go to **OptumRx.com** or scan the QR code below
2. Select Register on the home page
3. Enter the information from your member ID card
4. Create a username and password
5. Complete your profile

If you already have an account, sign in using your username and password.

Scan here to go to **OptumRx.com**

The OptumRx app makes the online pharmacy experience as simple as possible. You can easily:

- Search drug prices at multiple pharmacies
- Locate a network pharmacy
- Manage medication reminders
- Access your ID card if your plan allows

Manage home delivery orders

- Transfer a prescription to home delivery
- Track your order
- Refill a prescription

OPTUMRx®

Let us bring your medications to you

With Optum® Home Delivery, you can get a 3-month supply of your long-term medications. Plus, we mail them to you with free standard shipping.

Want more reasons?

Skip the trips

We deliver your medication to your door. You don't even have to leave home or wait in the pharmacy line.

Save money

You may pay less than what you do at in-store pharmacies. And, standard shipping is free.

Stay on track

With a 3-month supply, you may be less likely to miss a dose. You can even sign up for automatic refills.

Flexible Payment Options

Make one payment upfront. Or split it up into 3 equal monthly payments.

We're here when you need us

Use the website and app any time to track orders, request refills, price medications and more. Pharmacists and customer support team are available 24/7.

Ready for home delivery?

Here are the ways to sign up.

- **optumrx.com** or with the Optum Rx app.
- Or ask your doctor to send an electronic prescription to Optum Rx.
- Or call the number on your member ID card.

Scan code. Log in. Sign up.

Optum

WHAT'S AN HSA?

HEALTH SAVINGS ACCOUNT – PLAN INCLUDED WITH HSA MEDICAL

An HSA is a tax-advantage savings account that can be used to pay for healthcare expenses. Money is automatically pulled from your paycheck and deposited into this savings account. You pick the amount and can change the amount or stop deposits any time you would like. This savings account now becomes your primary way of paying for out-of-pocket medical expenses throughout the year.

BIG HSA BENEFITS

It saves you money. This is a cost-friendly option when it comes to medical premiums. Plus, HSAs are basically "cash" accounts, so you may be able to negotiate pricing on many medical services.

It's portable. If you change jobs, you get to keep your HSA.

It's a tax saver. Contributions to your HSA are made with pre-tax dollars. Since your taxable income is decreased by your contributions, you pay less in taxes.

It allows for an **improved retirement account**.

Funds roll over at the end of each year and accumulate tax-free, as does the interest on the account. Also, once you reach the age of 55, you are allowed to make additional catch-up contributions to your HSA until age 65.

It puts money in your pocket! You never lose unused HSA funds. They always roll over to the next year.

2025 CONTRIBUTION LIMITS

Individual Coverage: You can contribute up to $4,300 to an HSA.

Family Coverage: You can contribute up to $8,550 to an HSA. Any balance remaining in the HSA at the end of the calendar year will roll over to the next year.

If you are age 55 or older, you can contribute an extra $1,000.

***HSA only available for employees who choose HDHP, per federal statute.**

Health Savings Account (HSA) Contributions

For those employees choosing the High Deductible Health Plan (HDHP) with HSA option, active fulltime employees will receive an HSA contribution made by the City into the employee's account:

$1,000 Single
$1,500 Employee + Spouse
$1,500 Employee + Children
$1,500 Family

You may contribute to your HSA the maximum amount as determined by the IRS, regardless of your plan's deductible. The maximum for 2025 is $4,300 for individuals and $8,550 for families. If you have not been working at the City of Columbus long enough to receive a paycheck, you will not be eligible for the employer HSA contribution amount indicated above.

Individuals 55 and older may contribute an additional $1,000 each year for self only or family level contributions.

The IRS only allows "embedded" deductibles for family, HSA plans whose individual deductibles satisfy the minimum family deductible as determined by the IRS ($4,000). Since the $2,000 HSA plan's family deductible is $4,000, the $4,000 must be met by either an individual or family combined before benefits will start.

Early retirees are eligible to enroll in the High Deductible Health Plan but are not eligible for the employer contribution to the Health Savings Account.

If you are enrolling in an HSA for the first time, shortly after you submit your enrollment form, you will receive instructions on how to setup your HSA Account.

The City of Columbus offers two options for your HSA account:

- **First Financial Bank**
- **Lively**

*HSA only available for employees who choose HDHP, per federal statute.

Why Choose an HSA Plan?

An HSA is a bank account where tax-free deposits are made to pay for qualified medical expenses. Withdrawals from your HSA are also tax free as long as the funds are used for qualified medical expenses. There are many advantages to enrolling in a qualified High Deductible Health Plan and opening a HSA bank account.

You are eligible to enroll in one of the City of Columbus Employee HSA Plans if you meet the following requirements:

- Have no other first-dollar medical coverage. This means you cannot be covered as secondary under a plan that is not a qualified High Deductible Plan.
- Are not enrolled in Medicare. Medicare eligible persons who do not enroll in Medicare may have an HSA if they are covered by a qualified High Deductible Health Plan.
- Cannot be claimed as a dependent on someone else's tax return

What are the benefits of an HSA?

- Your high deductible insurance and HSA protect you against high or unexpected medical bills
- Your health insurance premiums are lower
- SIHO pays 100% of covered preventive care services received in-network. You do not need to meet the deductible for covered preventive care services.
- You can use the funds in your account to pay for the following:
    - Medical Expenses including expenses that are not covered under the SIHO Medical Plan (See IRS Publication 502)
    - All options under IRS Publication 502
    - Long-Term Care Insurance
    - Dental and Vision expenses
    - Medical expenses after retirement (before Medicare)
    - Out-of-pocket expenses when covered by Medicare
- You can save the money in your account for future medical expenses and grow your account through investment earnings. HSA earnings grow tax-free.
- Your HSA is completely portable. Funds in your HSA belong to you and are always 100% vested. There are no "use it or lose" rules for HSAs.
- Unlike contributions into an HSA, an individual need not be covered by an HDHP to make withdrawals from the HSA. For example, an employee that is qualified to contribute to an HSA can use the funds to pay for medical expenses for a qualified dependent even if the dependent is not covered under an HDHP.

Paying for medical expenses:

Here are a few simple tips to keep in mind:

- When you receive services from a physician or hospital, present your SIHO Identification Card just as you would with a traditional plan. Use of the ID Card ensured that the claims will be submitted to SIHO and that a provider network discount will be taken. This saves money for you! Most providers will not require payment from you at the time of service; they will bill SIHO and wait for payment determination from SIHO before billing you.
- Qualified healthcare expenses may be paid with your HSA money, or you may pay out-of-pocket and continue to save in your HSA.
- Your HSA works like a checking account with withdrawals limited only by the account balance.
- After you open your HSA, you have the option to receive a First Financial Debit Card. This card can be used to pay for qualified expenses anywhere it is accepted. You may also setup bill-payer and pay your medical bills online with First Financial.
- Receipts of where you spend your HSA funds are required by the IRS. You do not need to submit a receipt to the bank to receive reimbursement.
- However, you need to keep the receipt for 7 years with your other tax reporting paperwork.

Health Savings Account Example

HSA Savings compared to PPO with no HSA

SIHO INSURANCE SERVICES	PPO Plan ($2,500 Family Deductible)	HSA ($4,000 family Deductible)
Annual Premium	$4,256.72	$2,835.30
Employee HSA Deposit	$0	$750
City of Columbus HSA Match	$0	$1,500
*Assumed Annual Medical – 750 expenses not covered by insurance	$750 (paid out of pocket)	$750 (paid from HSA Account)
Total Employee Cost	$5,006.72	$3,585.30
HSA Account Balance at end of year	$0	$1,500 $750 EE & $1,500 City of Columbus Deposit minus $750 Expenses = $1,500)

Lively

Top 5 Reasons to Choose an HSA

Is a Health Savings Account right for you?

A Health Savings Account (HSA) is the most tax-advantaged account in America. And a Lively HSA is the perfect complement to your HSA-qualified health plan. In fact, HSAs are designed to help you pay less for out-of-pocket expenses.

Here are five reasons why you should open an HSA during open enrollment.

01 | Save up to 35% on health care expenses

Pay for a broad range of today's health care expenses with tax-free dollars. This helps you save up to 35%[1] on every out-of-pocket cost. That's like having $100 to spend rather than $65. Qualified expenses include your health plan deductible (doctors, labs, prescriptions, hospitalization). Plus vision, dental, chiropractic, and mental health services.

02 | Take advantage of lower premiums

The monthly premium for an HSA-qualified health plan is usually lower than other plan choices. Deposit the difference into your HSA with every pay period and watch your savings grow.

03 | Enjoy immediate tax savings with no hassle

Funds are securely deposited into your HSA from your paycheck, pre-tax. And are available to spend with your Lively HSA Visa debit card.

04 | Funds never expire

It's your choice. Spend your HSA money today. Or save it for tomorrow with confidence. Either way, the money is always available to spend—even if you change health plans or employers.

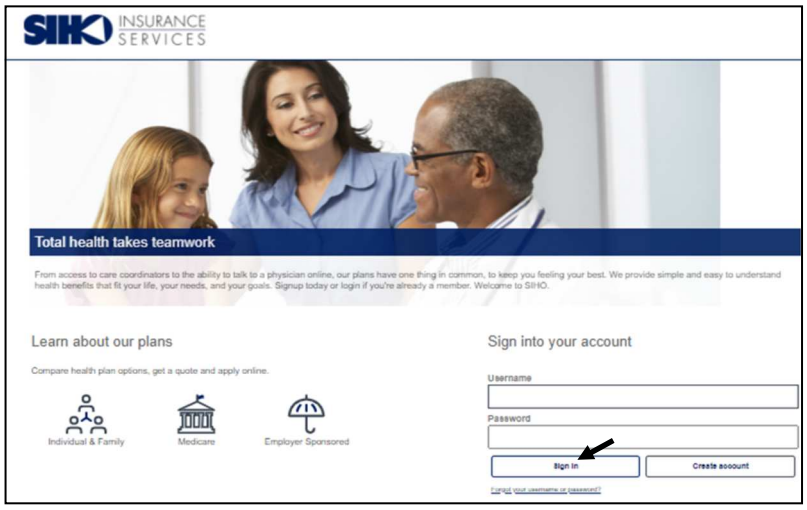
05 | Like a 401(k), for healthcare

Grow your nest egg and peace of mind by saving for future or unexpected healthcare expenses. With the option to invest[2] your savings, just like you can with a 401(k). But with the flexibility to spend the funds anytime, from today through retirement.

[1] Talk to a tax advisor about your savings potential; your savings may vary. The 35% example includes 24% federal tax savings, 7.65% payroll tax savings, and 3.35% state tax savings. Payroll tax savings are only available on deposits made through your employer's payroll. State tax savings are not available in states without income taxes or in California or New Jersey.

[2] Investments are not guaranteed, not insured, and may lose value.

ACCESSING YOUR MEMBER PORTAL



Visit www.siho.org to access the member portal.

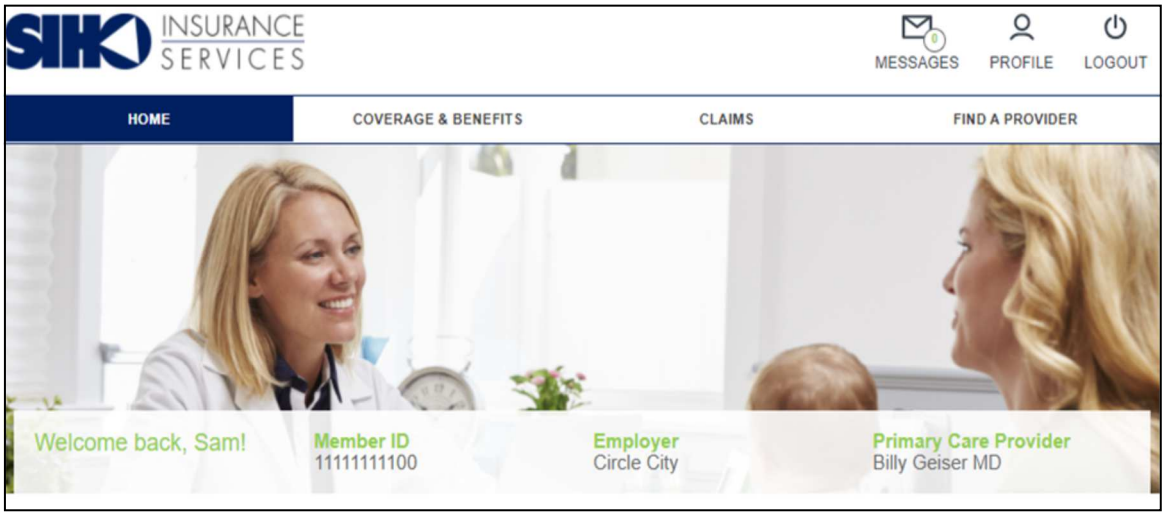
Existing users, click "Sign in".

If you are a new user, click "Create account".

SIHO Member Services
member.services@siho.org
812.378.7070

As a feature of your health care benefits, SIHO provides secure internet access to give you information you need anytime you need it.

Some of the following features.



Claims

SIHO provides quick access to your claims status and eligibility information. You can track your medical claims as they move through the SIHO claims processing system.

Utilization

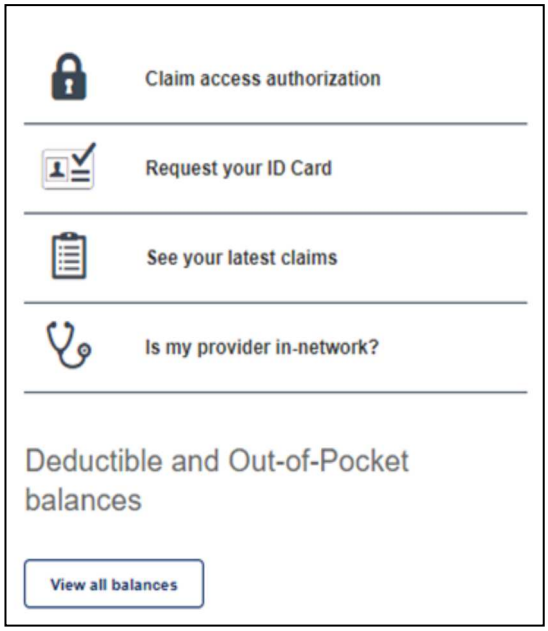
View up-to-date information on Deductibles, Out-of-Pocket Limits & Preventive Health Benefits usage.

Provider Lookup

Search for healthcare providers in your network by Specialty, Name or Location.

Plan Documents

Verify benefits related to your current plan.



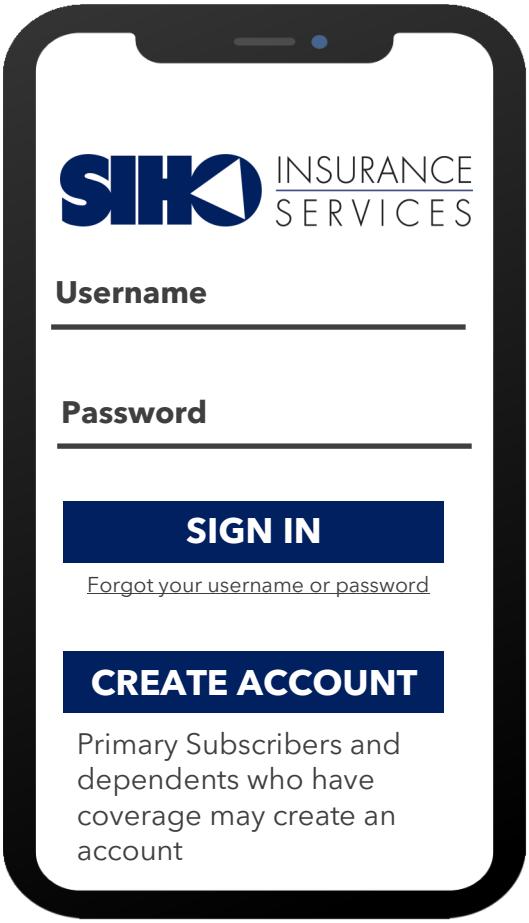
GET YOUR HEALTH INFO, WHEREVER YOU GO!

When you're out and about, the app puts your health plan at your fingertips.

Download it today to get instant access to your health plan details.

Available for Apple and Android!
Search "SIHO"

If you have questions, give us a call at 812-378-7070.
Hours: Monday - Friday | 8 AM - 6PM ET



FEATURES:

- **View Eligibility:** Shows active coverage and accumulator information such as total amount, paid amount, deductible identifiers, In-Network vs. Out-of-Network, and Individual vs. Family.
- **View Claims:** Configurable view of claim detail, claim status, date, provider, and patient responsibility.
- **Manage User Accounts:** Multiple options for members to manage their user account, including options for dependents.
- **Receive Push Notifications:** When a secure message has been sent a push notification as well as a badge notification will be sent to your mobile device.
- **Send Secure Messages:** Send questions to customer service about claims, eligibility, primary care physician changes, address changes, and request a new ID card.

Note: If you already have a Log-In account under the Member Portal, then your Log-In information for the Mobile App will be the same.

ID Card

Click on ID Card icon and email to recipient

OR

- Click on ID Card Icon and save for future access without logging into the mobile app in the future.
- Click on Confirm and logout of the mobile app
- For future access, simply click on the **View ID Card** button at the bottom of the mobile app
- Pinch, zoom and adjust your ID Card to display as needed

Account Type	Types of Coverage	Applicability	Minimum Employee Contribution	Maximum Employee Contribution	Employer Contribution Amount
FSA/Flexible Spending Account	**PPO** from City, or no City insurance	FSA	$5.00 per pay/$130 annually	$123.07 per pay/$3,200 annually	None
HSA/Health Savings Account	**HDHP** (High Deductible Healthcare Plan)	HSA	$5.00 per pay/$130.00 annually	Employee Only: $126.92 per pay $4,300 annually including $1,000 City contribution Employee Plus: $271.15 per pay $8,550 annually including $1,500 City contribution	Employee Only: $500 in Jan/$500 in July ($1,000 annually) Employee Plus: $750 in Jan/ $750 in July ($1,500 annually)
	Eligibility				
Dependent Care Flexible Spending Account	Any full-time employee who is a caregiver for a child under the age of 13, or an elderly family member, or family member who is disabled	Preschool, before or after school care, summer camp, adult day care or caregivers Dependent FSA	$5.00 per pay/$130 annually	$192.30 per pay if individual/ married/filing jointly ($4,999.80 annually) $96.15 per pay if married/filing separately ($2,499.90 annually)	None
Limited Dental/ Vision Flexible Spending Account	NOTE: Available to full-time employees electing HDHP coverage, or those electing no coverage at all	Can **ONLY** spend on Dental/ Vision expenses Flex Limited	$5.00 per pay/$130 annually	$117.30 per pay ($3,049.80 annually)	None

EHP HEALTH CLINIC AT NEXUSPARK (EHP)

FREE EMPLOYEE HEALTH AND WELLNESS CLINIC

WHAT IS EHP?

EHP Health Clinic at NexusPark is a practice managed through a collaborative relationship with Columbus Regional Health. The City of Columbus has contracted for this dedicated employee healthcare solution to serve our employees and family members.

The City of Columbus Health Clinic is available for use by any employee, retiree, or dependent covered under the City of Columbus health insurance (SIHO). Use of the clinic is a win-win for the City of Columbus and employees. You receive healthcare services in the clinic with no co-pay, and the City saves on healthcare costs through this dedicated, lower-cost service.

There is **NO CO-PAY for visits, labs or medications provided within the center.** Services in the center are paid for by the City of Columbus at a discounted cost, allowing both you and the City of Columbus to save money on healthcare costs.

SERVICES OFFERED AT EHP INCLUDE:

- Primary and preventive care
- Pharmacy Services
- Immunizations
- DOT and sports physicals
- Laboratory Services
- Weight Management Services
- Health Assessments and Wellness
- Screening Services
- Health Coaching Services
- Chronic Care Management

MONDAY: 7AM - 5PM
TUESDAY: 7AM - 5PM
WEDNESDAY: 8AM - 6PM
THURSDAY: 8AM - 5PM
FRIDAY: Closed
SATURDAY: 7AM - 12PM
SUNDAY: Closed

NEED A SAME DAY APPOINTMENT?
CALL **376-5450** OR USE THE ONLINE APPOINTMENT SYSTEM LINK AT:
www.crh.org/mychart

CITY OF COLUMBUS HEALTH CLINIC

Phone: 812-376-5450 Fax: 812-375-8879
2100 25th Street, Ste I, Columbus, IN 47201

SIHO Customer Service

The SIHO Customer Service staff includes:

Member Services – Representatives who will help you understand your health care benefits and walk you through the claims process.

Medical Management – Nurses are available on site to answer any medical questions you might have or to work with your physician to ensure you receive the highest quality health care.

Account Management – These individuals work with your employer to help them understand how the benefit program is working and to troubleshoot any concerns.

Though City of Columbus cannot avoid the impact of rising health care costs, we believe this health care plan will provide many advantages while living within the city's budget demands.

Advantages of the City of Columbus Plan:

- Two health plans – offering a choice in health care coverage
- Preventive health care coverage, with required educational meetings
- Extensive network of in-network providers
- On the PPO Plan Only, ALL labs are covered at 100% at CRH and affiliated providers

Customer Service:

SIHO has customer service representatives available to answer your questions relating to eligibility, benefits and claim status. You can also log on to their website and click on *Contact Us* to reach a customer service representative.

Phone: Local: 812.373.9703 Toll Free: 844.425.4281
Website: www.siho.org
Address: 417 Washington Street
P.O. Box 1787
Columbus, IN 47202-1787

To find out if your provider is part of the Inspire Network or to find a provider in the Inspire Network, call SIHO Customer Service or log on to the website to do a search: **www.siho.org**

Peace of Mind When Traveling

Travel assistance

Emergencies happen, but help is now only a phone call or email away. On Call International® offers a suite of services to help you in your time of need — from small inconveniences like losing your luggage to life-threatening situations — all delivered with a caring, human touch.

Find comfort in knowing you and your loved ones are protected by the Travel Assistance benefit when traveling more than 100 miles from home for business or leisure. The Travel Assistance benefit protects you when covered under a OneAmerica® company group life insurance policy. It also extends coverage to your spouse, domestic partner and children (under 21 or 25 and living at home as a full-time student) even when they are traveling without you. The Travel Assistance benefit requires no additional premium; however, exclusions do apply.

Medical assistance and transportation services

Pre-trip plan to provide up-to-date information regarding required vaccinations, health risks, travel restrictions and weather conditions.

Medical monitoring and review of documentation utilizing professional case managers and medical professionals to ensure appropriate care is received.

24-hour nurse help line to provide clinical assessment, education and general health information.

Replacement of prescriptions and eyeglasses that have been lost or stolen by consulting with the prescribing provider to transfer prescription to or arranging an appointment with a local provider.

Medical, behavioral or mental health, dental and pharmacy referrals to assist in finding care providers and medical facilities.

Coordination of benefits by requesting health information from the participant and attempting to coordinate benefits during an active travel assistance case.

Emergency medical evacuation to arrange and coordinate air and/or ground transportation and medical care during transportation to the nearest hospital where appropriate care is available.

Medical repatriation to arrange the transport of the participant with a qualified medical attendant, if medically necessary, to their residence or home hospital.

Return of remains to arrange the transportation of a participant's remains to their home in the event of their death while traveling.

24-hour travel assistance

Travel Assistance is made available through OneAmerica® by an agreement with On Call International®

1-866-816-2103 (US/Canada)

1-603-328-1754 (call collect from other locations)

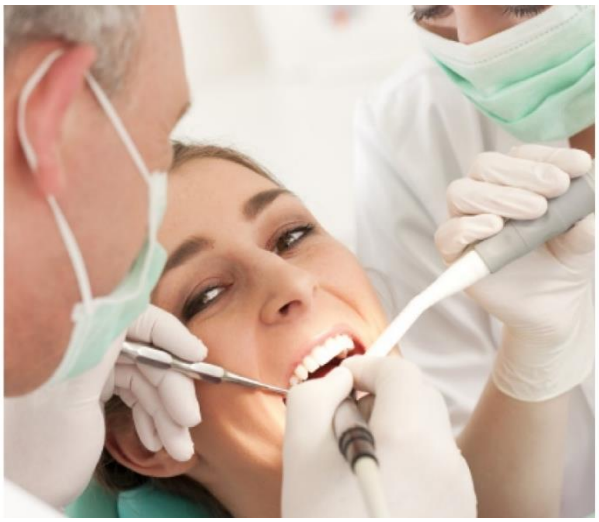
Email: **mail@oncallinternational.com**

G-33508 01/08/20

DENTAL INSURANCE

NETWORK ACCESS PLANS THROUGH GUARDIAN

In addition to protecting your smile, dental insurance helps pay for dental care and usually includes regular checkups, cleanings, and X-rays. Several studies suggest that oral diseases, such as periodontitis (gum disease), can affect other areas of your body—including your heart. Receiving regular dental care can protect you and your family from the high cost of dental disease and surgery.



The following chart outlines the Tier 1 dental benefits we offer for 2025.

		Amount You Pay	
Type of Service		**Option 1**	**Option 2**
Preventive Services		Exams, cleanings, X-rays—**$0**	Exams, cleanings, X-rays—**$0**
Deductible		Applies to basic and major services only— **$50 Deductible**	Applies to basic and major services only— **$50 Deductible**
Basic Services		Fillings, simple extractions—**40% Coinsurance**	Fillings, simple extractions—**20% Coinsurance**
Major Services		Oral surgery, root canal, crowns—**60% Coinsurance**	Oral surgery, root canal, crowns—**50% Coinsurance**
Annual Maximum		**$1,000**	**$1,500**
Biweekly Payroll Deductions			
	Employee Premiums	**Employee Only: $16.03** **Employee + 1: $31.28** **Family: $47.95**	**Employee Only: $20.47** **Employee + 1: $39.87** **Family: $61.35**

VISION INSURANCE

NETWORK ACCESS PLANS THROUGH GUARDIAN

Driving to work, reading a news article, and watching TV are all activities you likely perform every day. Your ability to do all of these activities, though, depends on your vision and eye health. Vision insurance can help you maintain your vision as well as detect various health problems.

City of Columbus's vision insurance entitles you to specific eye care benefits. Our policy covers routine eye exams and other procedures, and provides specified dollar amounts or discounts for the purchase of eyeglasses and contact lenses. The following chart outlines the In-Network vision benefits we offer for 2025.

		Amount You Pay	
Type of Service		**VSP Network**	**Davis Network**
Exam Copay		**$10**	**$10**
	Frequency	Once per Calendar Year	Once per Calendar Year
Base Lenses			
	Single	100% Covered	100% Covered
	Bifocal	100% Covered	100% Covered
	Trifocal	100% Covered	100% Covered
	Frequency	Once per Calendar Year	Once per Calendar Year
Contact Lenses (Elective)		**$130**	**$130**
	Frequency	Once per Calendar Year	Once per Calendar Year
Frame Retail		**$130**	**$130**
	Frequency	Every Other Calendar Year	Every Other Calendar Year
Biweekly Payroll Deductions			
	Employee Premiums	**Employee Only: $5.36** **Employee + 1: $8.13** **Family: $14.31**	**Employee Only: $4.41** **Employee + 1: $6.69** **Family: $11.75**

DISABILITY INCOME BENEFITS

SHORT-TERM DISABILITY / LONG-TERM DISABILITY

The City of Columbus provides full-time employees with long-term disability income benefits. Without disability coverage, you and your family may struggle to get by if you miss work due to an injury or illness.

At City of Columbus, we want to do everything we can to protect you and your family. That's why City of Columbus pays for the full cost of long-term disability insurance—meaning that you owe nothing out of pocket.

	Short-term Disability	Long-term Disability
	SIHO INSURANCE SERVICES	ONEAMERICA®
Benefits Begin	Injury: Day 1 Illness: Day 8 Maximum length of STD is 91 days.	Injury: 91st Day Sickness: 91st Day
Pre-Existing Condition Period	N/A	3 months / 12 months
Percentage of Income Replaced	60% of weekly salary up to a maximum of $600.00 per week	60% of your monthly pre-disability earnings, up to a maximum monthly benefit of $5,000
Employee Premiums	Coverage is provided at no cost to you. The City of Columbus pays 100% of the total premium.	Coverage is provided at no cost to you. The City of Columbus pays 100% of the total premium.

LIFE INSURANCE BENEFITS

BASIC LIFE INSURANCE / VOLUNTARY LIFE INSURANCE

BASIC LIFE INSURANCE – ONE AMERICA

Life insurance can help provide for your loved ones if something where to happen to you. City of Columbus provides full-time employees with $20,000 in group life and accidental death and dismemberment (AD&D) insurance. City of Columbus pays for the full cost of this benefit—meaning you are not responsible for paying any monthly premiums. Contact Human Resources if you would like to update your beneficiary information.

VOLUNTARY LIFE INSURANCE – ONE AMERICA

While City of Columbus offers Basic life insurance, some employees may want to purchase additional coverage. Think about your personal circumstances. Are you the sole provider for your household? What other expenses do you expect in the future (for example, college tuition for your child)? Depending on your needs, you may want to consider buying supplemental coverage.

With Voluntary life insurance, you are responsible for paying the full cost of coverage through biweekly payroll deductions. The maximum life insurance you can purchase for yourself if $500,000 or up to 5x your annual salary. You can purchase coverage for your spouse in increments of $5,000, up to $20,000 maximum.

The chart below outlines the monthly costs of purchasing additional coverage.

Payroll Deduction Illustration: Bi-Weekly
Employee Options

Life & AD&D	0-19	20-24	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70-74	75+
$20,000	$.60	$.60	$.60	$.68	$.94	$1.53	$2.64	$4.51	$8.94	$11.76	$19.68	$19.68	$19.68
$25,000	$.75	$.75	$.75	$.85	$1.17	$1.91	$3.30	$5.64	$11.18	$14.70	$24.60	$24.60	$24.60
$30,000	$.90	$.90	$.90	$1.02	$1.41	$2.29	$3.96	$6.77	$13.41	$17.64	$29.52	$29.52	$29.52
$40,000	$1.20	$1.20	$1.20	$1.37	$1.89	$3.07	$5.28	$9.03	$17.89	$23.52	$39.36	$39.36	$39.36
$50,000	$1.50	$1.50	$1.50	$1.71	$2.36	$3.83	$6.60	$11.29	$22.36	$29.40	$49.20	$49.20	$49.20
$60,000	$1.80	$1.80	$1.80	$2.05	$2.83	$4.60	$7.92	$13.54	$26.83	$35.28	$59.04	$59.04	$59.04
$70,000	$2.10	$2.10	$2.10	$2.39	$3.29	$5.36	$9.24	$15.80	$31.31	$41.16	$68.88	$68.88	$68.88
$80,000	$2.40	$2.40	$2.40	$2.73	$3.76	$6.13	$10.56	$18.05	$35.78	$47.04	$78.72	$78.72	$78.72
$90,000	$2.70	$2.70	$2.70	$3.07	$4.23	$6.89	$11.88	$20.31	$40.25	$52.92	$88.56	$88.56	$88.56
$100,000	$3.01	$3.01	$3.01	$3.42	$4.71	$7.67	$13.21	$22.57	$44.73	$58.81	$98.41	$98.41	$98.41

Spouse Options

Life & AD&D	0-19	20-24	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70-74	75+
$5,000	$.15	$.15	$.15	$.17	$.23	$.38	$.66	$1.13	$2.24	$2.94	$4.92	$4.92	$4.92
$10,000	$.30	$.30	$.30	$.34	$.47	$.76	$1.32	$2.26	$4.47	$5.88	$9.84	$9.84	$9.84
$15,000	$.45	$.45	$.45	$.51	$.70	$1.15	$1.98	$3.38	$6.71	$8.82	$14.76	$14.76	$14.76
$20,000	$.60	$.60	$.60	$.68	$.94	$1.53	$2.64	$4.51	$8.94	$11.76	$19.68	$19.68	$19.68

Child Options

Life & AD&D	Child(ren) 6 months to age 26	Child(ren) live birth to 6 months	Deduction amount Child(ren)
Option 1:	$2,500	$1,000	$0.23
Option 2:	$5,000	$1,000	$0.46
Option 3:	$7,500	$1,000	$0.69
Option 4:	$10,000	$1,000	$0.92

Life comes with challenges.

Your Assistance Program is here to help.

Your Assistance Program can help you reduce stress, improve mental health, and make life easier by connecting you to the right information, resources, and referrals.

All services are free, confidential, and available to you and your family members. This includes access to short-term counseling and the wide range of services listed below:

Mental Health Sessions (Six Sessions)
Manage stress, anxiety, and depression, resolve conflict, improve relationships, overcome substance abuse, and address any personal issues.

Life Coaching
Reach personal and professional goals, manage life transitions, overcome obstacles, strengthen relationships, and build balance.

Financial Consultation
Build financial wellness related to budgeting, buying a home, paying off debt, managing taxes, preventing identity theft, and saving for retirement or tuition.

Legal Consultation
Get help with personal legal matters including estate planning, wills, real estate, bankruptcy, divorce, custody, and more.

Work-Life Resources and Referrals
Obtain information and referrals when seeking childcare, adoption, special needs support, eldercare, housing, transportation, education, and pet care.

Personal Assistant
Save time with referrals for travel and entertainment, seeking professional services, cleaning services, home food delivery, and managing everyday tasks.

Medical Advocacy
Get help navigating insurance, obtaining doctor referrals, securing medical equipment or transportation, and planning for transitional care and discharge.

Member Portal and App
These digital tools enable you to access your benefits 24/7/365 with online requests and chat options. They also provide easy access to thousands of articles, webinars, podcasts, and tools covering total well-being.

Contact LifeServices EAP
Call: 800-822-4847
Visit: lifeserviceseap.com
Code: LS0313

LIFESERVICES EAP
An AllOne Health Company

Introducing Your **Member Portal and App**

Browse benefits. Request services.
Enjoy 24/7/365 access.

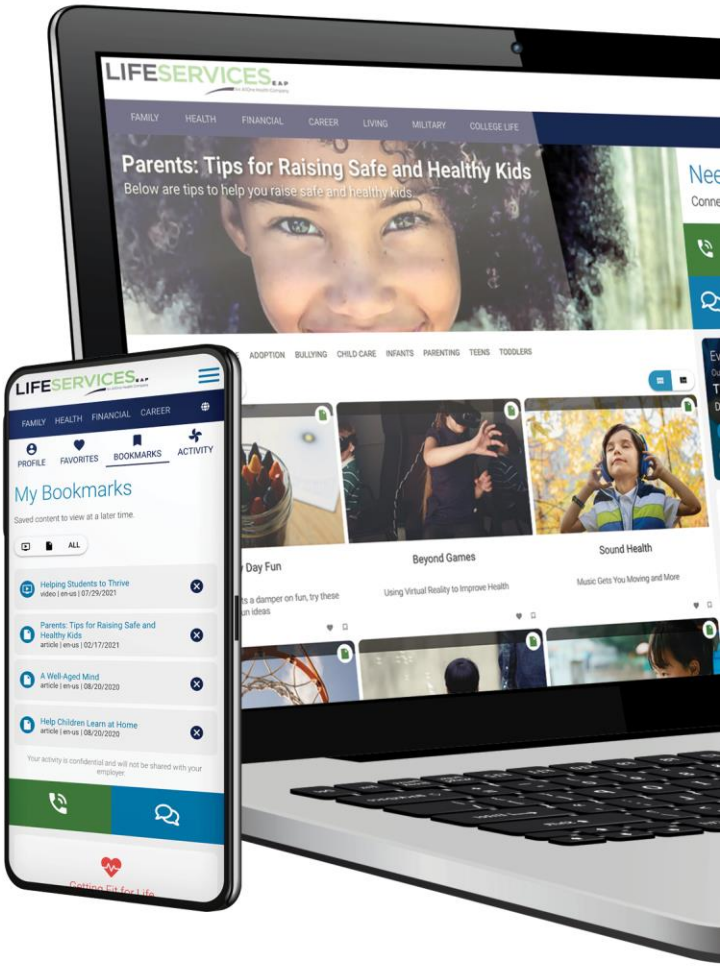
Your Assistance Program offers a wide range of benefits to help improve mental health, reduce stress and make life easier—all easily accessible through your member portal and app.

Video, Chat and Telephonic Access
24/7/365 access to request mental health sessions and life management referrals

Thousands of Self-Care Articles and Resources
Explore videos, provider resource locators, personal assessments, calculators and tools

Events Calendar and Free Webinars
Sign up for the latest webinars and online training sessions

Exclusive Discounts
Save money on entertainment, gifts, travel and consumer goods



Getting Started Is Easy

1. Visit your landing page, **LifeServicesEAP.com** and click on "Select Portal & App" in the top menu
2. Register to create a new account using your company code: **LSO313**
3. A confirmation email will be sent to complete the process

Contact LifeServices EAP
Call: 800-822-4847
Visit: LifeServicesEAP.com
Code: LS0313

LIFESERVICES EAP
An AllOne Health Company

IMPORTANT CONTACTS

BENEFITS OFFERED	PROVIDER	PHONE	WEBSITE / EMAIL
	Benefits Specialist	**812-376-2570**	**benefits@columbus.in.gov**
Medical & Short-term Disability	SIHO Insurance	812-378-7070	memberservices@siho.org
Find a Provider			Find a SIHO Provider
Dental	Guardian	1-888-482-7342	https://www.guardianlife.com/
Find a Provider			Find a Dentist (guardiananytime.com)
Vision	Guardian	1-888-482-7342	https://www.guardianlife.com/
Find a Provider			Find a Vision Provider (guardiananytime.com)
Health Savings Account	First Financial Bank	812-376-1848	
Health Savings Account	Lively	1-888-576-4837	hello@livelyme.com / https://livelyme.com
Flexible Spending Account	Lively	1-888-576-4837	hello@livelyme.com / https://livelyme.com
Life Insurance & Long-term Disability	OneAmerica	1-800-553-3522	LifeClaims.employeebenefits@oneamerica.com
Employee Assistance Program	Lifeservices (AllOne Health)	1-800-822-4847	https://allonehealthmemberportal.mylifeexpert.com/login Company Code: LS0313
Pharmacy Plan	Optum	1-800-356-3477 / 877-656-9604	www.optumrx.com/
Worksite	Aflac – Curt Carter	317-412-5176	
Travel Assistance	OneAmerica	(US/Canada) 1-866-816-2103 (Call Collect) 1-603-328-1754	mail@oncallinternational.com
Deferred Compensation	Edward Jones – Lisa Duke	812-378-3012	
Healthcare Navigator		812-376-5136	

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NEWBORNS' & MOTHERS' HEALTH PROTECTION ACT

Under the Newborn's & Mothers' Health Protection Act, the Plan may not restrict benefits for a hospital stay in connection with childbirth to less than 48 hours following a vaginal delivery or less than 96 hours following a cesarean delivery.

Plans may not require providers to obtain authorization from the plan for prescribing the stay. In addition, plans may not deny a stay within the 48-hour (or 96-hour) period because the plan's utilization reviewer does not think such a stay is medically necessary.

The plan must eliminate this preauthorization requirement with respect to hospital stays following vaginal delivery for the first 48 hours (or 96 hours in the case of a cesarean section).

The plan may impose such an authorization requirement for hospital stays beyond this period. In addition, the plan may impose a requirement on the mother to give notice of a pregnancy in order to obtain a certain level of cost-sharing or to use certain medical facilities. However, the type of preauthorization required by this plan (within the 48/96 hour period and based on medical necessity) must be eliminated.

For more information see www.dol.gov

SIHO INSURANCE SERVICES

There have been no changes to our Privacy Practices. If you would like a copy, you can find on our website at www.siho.org under Privacy Policy at the bottom of the web page or you can contact Member Services at (812)378-7070 or (800)443-2980.

WOMEN'S HEALTH & CANCER RIGHTS ACT

In accordance with the Women's Health and Cancer Rights Act of 1998, SIHO Insurance Services' covered members who undergo a mastectomy, and who elect breast reconstruction in connection with the mastectomy, are entitled to coverage for:

- Reconstruction of the breast on which the mastectomy was performed.
- Surgery and reconstruction of the other breast to produce a symmetric appearance.
- Prosthesis and treatment of physical complications at all stages of the mastectomy, including lymphedemas, in a manner determined in consultation with the attending physician and the patient.

The coverage may be subject to coinsurance and deductibles consistent with those established for other benefits.

For more information call SIHO at (812) 378-7070 or (800) 443-2980.

SIHO INSURANCE SERVICES

There have been no changes to our Privacy Practices. If you would like a copy, you can find on our website at www.siho.org under Privacy Policy at the bottom of the web page or you can contact Member Services at (812)378-7070 or (800)443-2980.

PREMIUM ASSISTANCE UNDER MEDICAID & CHIP (CHILDREN'S HEALTH INSURANCE PROGRAM)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit www.healthcare.gov.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial 1-877-KIDS NOW or www.insurekidsnow.gov to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and you must request coverage within 60 days of being determined eligible for premium assistance. If you have questions about enrolling in your employer plan, contact the Department of Labor at www.askebsa.dol.gov or call 1-866-444-EBSA (3272).

There have been no changes to our Privacy Practices. If you would like a copy, you can find on our website at www.siho.org under Privacy Policy at the bottom of the web page or you can contact Member Services at (812)378-7070 or (800)443-2980.

Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit **www.healthcare.gov**.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or **www.insurekidsnow.gov** to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at **www.askebsa.dol.gov** or call **1-866-444-EBSA (3272)**.

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2024. Contact your State for more information on eligibility –

ALABAMA – Medicaid	ALASKA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx
ARKANSAS – Medicaid	**CALIFORNIA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Health Insurance Premium Payment (HIPP) Program Website: http://dhcs.ca.gov/hipp Phone: 916-445-8322 Fax: 916-440-5676 Email: hipp@dhcs.ca.gov
COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	**FLORIDA – Medicaid**
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/State Relay 711 CHP+: https://hcpf.colorado.gov/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.mycohibi.com/ HIBI Customer Service: 1-855-692-6442	Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268

GEORGIA – Medicaid	INDIANA – Medicaid
GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162, Press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra Phone: 678-564-1162, Press 2	Health Insurance Premium Payment Program All other Medicaid Website: https://www.in.gov/medicaid/ http://www.in.gov/fssa/dfr/ Family and Social Services Administration Phone: 1-800-403-0864 Member Services Phone: 1-800-457-4584
IOWA – Medicaid and CHIP (Hawki)	**KANSAS – Medicaid**
Medicaid Website: Iowa Medicaid | Health & Human Services Medicaid Phone: 1-800-338-8366 Hawki Website: Hawki - Healthy and Well Kids in Iowa | Health & Human Services Hawki Phone: 1-800-257-8563 HIPP Website: Health Insurance Premium Payment (HIPP) | Health & Human Services (iowa.gov) HIPP Phone: 1-888-346-9562	Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-800-967-4660
KENTUCKY – Medicaid	**LOUISIANA – Medicaid**
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kynect.ky.gov Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms	Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)
MAINE – Medicaid	**MASSACHUSETTS – Medicaid and CHIP**
Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=en_US Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-977-6740 TTY: Maine relay 711	Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: 711 Email: masspremassistance@accenture.com
MINNESOTA – Medicaid	**MISSOURI – Medicaid**
Website: https://mn.gov/dhs/health-care-coverage/ Phone: 1-800-657-3672	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005

MONTANA – Medicaid	NEBRASKA – Medicaid
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HHSHIPPProgram@mt.gov	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
NEVADA – Medicaid	**NEW HAMPSHIRE – Medicaid**
Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext. 15218 Email: DHHS.ThirdPartyLiabi@dhhs.nh.gov
NEW JERSEY – Medicaid and CHIP	**NEW YORK – Medicaid**
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Phone: 1-800-356-1561 CHIP Premium Assistance Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710 (TTY: 711)	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
NORTH CAROLINA – Medicaid	**NORTH DAKOTA – Medicaid**
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Website: https://www.hhs.nd.gov/healthcare Phone: 1-844-854-4825
OKLAHOMA – Medicaid and CHIP	**OREGON – Medicaid and CHIP**
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: http://healthcare.oregon.gov/Pages/index.aspx Phone: 1-800-699-9075
PENNSYLVANIA – Medicaid and CHIP	**RHODE ISLAND – Medicaid and CHIP**
Website: https://www.pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html Phone: 1-800-692-7462 CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov) CHIP Phone: 1-800-986-KIDS (5437)	Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)
SOUTH CAROLINA – Medicaid	**SOUTH DAKOTA - Medicaid**
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://dss.sd.gov Phone: 1-888-828-0059

TEXAS – Medicaid	UTAH – Medicaid and CHIP
Website: Health Insurance Premium Payment (HIPP) Program | Texas Health and Human Services Phone: 1-800-440-0493	Utah's Premium Partnership for Health Insurance (UPP) Website: https://medicaid.utah.gov/upp/ Email: upp@utah.gov Phone: 1-888-222-2542 Adult Expansion Website: https://medicaid.utah.gov/expansion/ Utah Medicaid Buyout Program Website: https://medicaid.utah.gov/buyout-program/ CHIP Website: https://chip.utah.gov/
VERMONT– Medicaid	**VIRGINIA – Medicaid and CHIP**
Website: Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access Phone: 1-800-250-8427	Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs Medicaid/CHIP Phone: 1-800-432-5924
WASHINGTON – Medicaid	**WEST VIRGINIA – Medicaid and CHIP**
Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022	Website: https://dhhr.wv.gov/bms/ http://mywvhipp.com/ Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
WISCONSIN – Medicaid and CHIP	**WYOMING – Medicaid**
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since July 31, 2024, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0137.

The plans illustrated in this brochure are representative examples because plan details change from time to time. Your plan may have different benefits. Refer to your Certificate of Coverage for the specific benefits available to you. For more information on these plans, contact your authorized SIHO agent/broker or SIHO account coordinator.

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