Franklin County Cooperative
Health Improvement Program

HEALTHCARE BENEFITS GUIDE

Effective January 1, 2024

Last updated May 3, 2024

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614.525.5750
Benefits@franklincountyohio.gov

THRIVEON
614.525.3948
ThriveOn@franklincountyohio.gov

Franklin County Government Center
373 S. High Street, 25th floor | Columbus, OH 43215
BeWell.franklincountyohio.gov

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YOUR ELIGIBILITY AND YOUR DEPENDENTS' ELIGIBILITY

If you are an active employee scheduled to work at least 30 hours per week, you are eligible to participate in the Franklin County Cooperative Health Improvement Program.

Eligible Dependents Include:

- ✓ Legal spouse of employee (same or opposite gender; excludes ex-spouse and legally separated spouse)
- ✓ Domestic partner of employee (cannot be a legal spouse)
- ✓ Child(ren) (see below)

The following children are eligible to be covered **up to the end of the month in which the child turns age 26**.

- Natural child of employee
- Natural child of domestic partner (only if domestic partner enrolls)
- Stepchild of employee
- Legally adopted child of employee, spouse, or domestic partner
- Legal Ward (Child for whom legal guardianship has been awarded to employee, spouse or domestic partner
- Child for whom health care coverage is required through a "Qualified Medical Child Support Order" (QMCSO)
- Child of an enrolled dependent child, i.e., Grandchild of employee (child must enroll)

A disabled child of any age is eligible if the disabled status is certified and approved. (See **Exhibit 1** for restrictions.)

See **Exhibit 1** for detailed definitions of eligible dependents and the documentation that is required upon enrollment.

Any individual that is requested for coverage must meet the eligibility requirements. Coverage will be immediately terminated for any dependent who has not been verified and/or determined ineligible per the eligibility requirements. If a dependent loses eligibility, it is your responsibility to remove the dependent from your coverage. **ENROLLING AN INELIGIBLE DEPENDENT OR FAILURE TO REPORT A LOSS OF ELIGIBILITY OF A DEPENDENT IS CONSIDERED FRAUD AGAINST THE PLAN AND IS PUNISHABLE UP TO AND INCLUDING TERMINATION OF EMPLOYMENT.**

YOUR BENEFIT OPTIONS AND COST

Your benefit options are broken down into **THREE** categories:

Employer Paid Benefits

As a benefits eligible employee of the Franklin County Cooperative, you are automatically provided these benefits at no cost to you. Your employer pays 100% of the cost.

- $50,000 of Basic Life Insurance*
- $50,000 Accidental Death & Dismemberment (AD&D) Life Insurance*
  - AD&D pays an additional benefit in the event of accidental death or loss, i.e., loss of sight, loss of limb, quadriplegia, etc.
- Emotional Wellbeing Solutions (formerly EAP)
- ThriveOn Wellness Your Way Program

*Some bargaining units and/or agencies may provide higher or lower coverage amounts.

Employee Paid Benefits

As a benefits eligible employee of the Franklin County Cooperative, you have the opportunity to enroll in the following voluntary programs. Premiums/contributions are deducted from your paycheck.

- **Legal Program:** This program provides unlimited access to a nationwide network of attorneys. **You pay 100% of the post-tax $16.50 monthly premium.**
- **Additional (Supplemental) Life Insurance:** This program provides additional amounts of life insurance for yourself. Coverage may also be elected for your spouse, domestic partner or children. **You pay 100% of the post-tax premium**. Rates are provided in this guide.
- **Short- and Long-Term Disability:** This program provides replacement income if you are disabled due to illness or injury. You have the option of electing short and/or long-term disability. **You pay 100% of the post-tax premium**. Rates are provided in this guide.
- **Flexible Spending Accounts (FSA):** This program allows you to set aside pre-tax dollars from each paycheck to pay for unreimbursed qualified healthcare (Healthcare FSA) or dependent/elder care (Dependent Care FSA) expenses.. **FSA contributions are deducted from each paycheck and deposited into your FSA account**. Because contributions are collected from your paycheck pre-tax, your taxable income is reduced.

Employer and Employee Shared Cost Benefits

As a benefits eligible employee of the Franklin County Cooperative, you have the opportunity to enroll in the health plan. The plan offers a bundle of coverage which includes Medical, Behavioral Health, Prescription Drug, Dental and Vision. You cannot enroll in just medical or just dental; it is a bundle of all coverages.

- Please contact your agency HR/Payroll representative to obtain your monthly contribution amount.

YOUR BENEFIT OPTIONS AND COST

WHAT IF I DON'T ENROLL IN THE HEALTH PLAN?

If you decline enrollment in the health plan:

- Employer Paid Benefits are provided to you at no cost. **NOTE**: At least one primary beneficiary is required for the Basic Life Insurance.
- You may elect any Employee Paid Benefit.

Special Enrollment Notice

If you do not enroll yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in the Cooperative's plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward other coverage). However, you must request enrollment within **30 days** from when your dependents' other coverage ends (or after the employer stops contributing toward the other coverage). In addition, if you have a new dependent because of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within **30 days** from the marriage, birth, adoption, or placement for adoption. If you do not request enrollment within **30 days**, you are not able to make changes until the next Open Enrollment. See **Your Life Events** section.

YOUR DOMESTIC PARTNER AND TAXES

The Franklin County Cooperative offers coverage to same and opposite gender domestic partners of employees. The IRS does not recognize domestic partners or their children as 'qualified' dependents. Therefore, if you enroll a domestic partner, IRS tax rules impact your taxable income in the following ways:

- **Monthly Contribution**: Your monthly contribution is split pre- and post-tax if a domestic partner is enrolled. The amount to contribution associated with your coverage is collected from your paycheck pre-tax. The amount of contribution associated with your domestic partner is collected from your paycheck post-tax.

- **Fair Market Value:** The fair market value (FMV) of the domestic partner benefit is taxed as income. The FMV is the value of the domestic partner benefit. This can be a significant tax burden.

If you enroll a domestic partner and discover the additional taxes are too much, you will not be able to drop coverage for your domestic partner until the next Open Enrollment. You are encouraged to research your options thoroughly and to seek advice from a tax advisor prior to enrolling a domestic partner.

Refer to **Exhibit 1** to review the definition of a domestic partner.

A chart showing the fair market value of domestic partner coverage is available at BeWell.franklincountyohio.gov and posted in the online enrollment system.

YOUR NEW HIRE ENROLLMENT

You must enroll within
30 days from your date of hire.

Your benefits become effective on the 1st of the month following your date of employment. If you miss this initial enrollment opportunity you must wait until Open Enrollment to enroll.

Accessing the Enrollment System

The enrollment system is accessible from any device with internet access. If you do not have internet access available to you, contact your HR/Payroll Officer for assistance.

You will be asked to supply the following information during your first enrollment session:

- Social security numbers and dates of birth for each dependent being enrolled.
- Address for any dependent not living with you.
- Other coverage information for your dependent(s).

NOTE: You are asked to record your preferred telephone number and email address. It is important to remember to update them if they change.

Logging in for the First Time

Go to **fccBenefits.com**. Use the 3-step instructions below to establish your username and temporary password.

Step 1	Step 2	Step 3
Your Username is: FCC **+** first 3 characters of your first name **+** first 3 characters of your last name **+** your 2-digit day of birth **+** your 4-digit year of birth **Example:** If your name is John Smith and your birthdate is January 15, 1975, your username would be FCCJOHSMI151975.	Your initial (temporary) password is: First letter of your first name **+** first 3 characters of your last name **+** last 4 of your SSN **Example:** If your name is John Smith and your social security number is 123456789, then your password would be JSMI6789	Click on the **"Login"** button 

Your username and temporary password are all CAPATILIZED letters.
You will be prompted to change your password upon first login.

The 3-step login instructions are also included on the login page at **fccBenefits.com**.

YOUR REQUIRED DOCUMENTS

You must supply documentation to substantiate the eligibility of each dependent you enroll. **(See Exhibit 1)**

These documents must be submitted within 30 days of your date of hire. If you fail to supply the necessary documents, the request for coverage of your dependent will be denied, and the next opportunity to enroll your dependent will be during the following Open Enrollment.

Record your name and telephone number on each document. Upload your documents to the enrollment system. If you are unable to upload, other options are available. **Do not supply originals unless requested**.

How to submit your required documents:

PREFERRED METHOD	
Upload to the enrollment system	fccBenefits.com
ALTERNATIVE METHODS	
Send documents via post or inter-office mail or hand deliver to:	Franklin Country Benefits & Wellness 373 S. High Street, 25th Floor Columbus, OH 43215
Fax:	**614.525.5515**
Email:	Benefits@franklincountyohio.gov

OPEN ENROLLMENT & LIFE EVENTS

Your Open Enrollment

Open Enrollment occurs annually and is your opportunity to make changes to your benefit elections. **Changes are effective January 1st.** You may add/remove dependents to your coverage and enroll/disenroll in health or voluntary programs. Documents to substantiate eligibility are required when adding a dependent at Open Enrollment. See **Exhibit 1** in this guide for a list of required documents.

Flexible Spending Account (FSA) elections must be made every year. If you currently have FSA coverage and would like to continue coverage in the following plan year, you must make your elections during Open Enrollment.

Each year during Open Enrollment you may be eligible to increase your Employee and/or your Spouse Supplemental Life insurance by $10,000 without submitting Evidence of Insurability (EOI). This is referred to as the **$10,000 bump**. Eligibility for the "$10,000 bump" requires active current enrollment in Supplemental Life Insurance and cannot exceed the maximum election permitted under the plan. The "$10,000 bump" must be requested during your annual Open Enrollment session.

Your Life Events

Life Events are major life events that occur outside of Open Enrollment that can change your benefit needs. Certain qualifying life events allow you to change your benefits before the next annual Open Enrollment. These events are listed on the following page. You may change your health, your life, legal, and your disability insurance coverage, and in some circumstances, your FSA. Adding a spouse or domestic partner can also impact your wellness program incentives.

All Life Events must be submitted at fccBenefits.com within 30 days of a Life Event (marriage, birth, divorce, adding/subtracting a dependent, etc.). See **Exhibit 1** in this guide for a list of required documents when adding a dependent. The chart on the following page provides required documents for removing a dependent. All documents must be submitted within 30 days of the date of the Life Event.

A legal separation, dissolution or divorce or ending a domestic partnership is a difficult and life-altering process and can be emotionally and financially challenging and require legal consultation.

- The **Emotional Wellbeing Solutions** (formerly EAP) provides individual, family or relationship counseling and emotional support. This is at no cost to you.
- **Enrich Financial Wellness** can assist in setting financial goals, developing budgets and offers one-on-one consultation with financial coaches. This is at no cost to you.
- **MetLife Legal Plans** provide access to a network of experienced attorneys. Divorce, dissolution, and annulment as well as child support assistance is available. This is a voluntary program with you paying 100% of the monthly premium.

It is important to remember that it is your responsibility to notify the Benefits & Wellness Office of any change in eligibility of a spouse or domestic partner. YOU MUST:

- Notify the Benefits & Wellness Office within **30 days** of a court approved legal separation, divorce, or dissolution; or
- Complete an Affidavit of Termination of Domestic Partnership within **30 days** of terminating a domestic partnership.

Failure to report the loss of eligibility of a dependent or notify the Benefits & Wellness Office within these timeframes and keeping an ineligible dependent on your plan, is considered fraud against the plan and is punishable up to and including termination of employment.

OPEN ENROLLMENT & LIFE EVENTS

The chart below illustrates various Life Events; and the documentation that is required.

All Life Events must be submitted online at fccBenefits.com. Click on "**Life Event**" and then click on the box that describes the life event. If you are unsure what Life Event to select, please contact the Benefits & Wellness Office for direction. Submit the required dependent verification documents directly to the Benefits & Wellness Office or upload in the enrollment system. **You must notify the Franklin County Benefits & Wellness Office within 30 days of a Life Event.**

Life Event	Effective Date of Coverage Change	Required Documentation
Marriage	The first day of the month following the date of the marriage	**Refer to Exhibit 1 Definitions and Required Documents**
Domestic Partner	The first day of the month following the date the Affidavit is notarized	**Refer to Exhibit 1 Definitions and Required Documents**
Birth	Date of Birth	**Refer to Exhibit 1 Definitions and Required Documents**
Adoption/Legal Guardianship	Date of Court Documents	**Refer to Exhibit 1 Definitions and Required Documents**
Terminating your Cooperative coverage as a result of a gain of other coverage	The last day of the month preceding the begin date of other coverage (if other coverage begins first of the following month) or the last day of the month in which other coverage begins if mid-month	**Documentation from the other plan, indicating the date coverage begins**
Enrolling in Cooperative coverage because of a loss of other coverage	The day immediately following the date the other coverage ends	**Documentation from the other plan, indicating the date coverage ends.** **Refer to Exhibit 1 Definitions and Required Documents if enrolling dependents**
Divorce/Dissolution/ Legal Separation	Date of Court Documents	**Court approved divorce/dissolution decree or separation agreement**
Termination of Domestic Partnership	Date illustrated on Affidavit of Termination of Domestic Partnership	**Affidavit of Termination of Domestic Partnership**
Dependent Child no longer eligible	The last day of the month in which the child became ineligible	**Written request must be made to the Benefits & Wellness Office to remove child from plan, stating reason for loss of eligibility**. Additional documentation may be requested.
Death of Employee	Employee coverage ends the date of death. Dependent coverage continues through the end of same month.	Copy of the **death certificate or obituary. If a life insurance claim is filed, a life insurance claim form and an original (not a copy) death certificate are required.**
Death of Dependent	Dependent coverage ends the date of death	

OPEN ENROLLMENT & LIFE EVENTS

Your Status Changes from Part-time or Full-time

If your status changes from part-time to full-time and you become eligible for benefits, you will enroll as if you are a New Hire, with the date you are placed in a full-time status as your date of hire. Follow the instructions in the **Your New Hire Enrollment** section of this guide.

You Transfer to a New Agency

If you transfer to a new agency within the Cooperative within 30 days or less of leaving your old agency, there will be no break in coverage. You will be treated as a New Hire if your break in employment is greater than 30 days.

Your Employee Information in fccBenefits.com

Contact your HR/payroll officer if corrections are needed to the following information. **You cannot make these changes yourself.**

- Name
- Mailing Address
- Work Email Address
- Work Phone Number
- Social Security Number
- Birth Date
- Gender
- Department

Your Employment Termination

If your employment terminates:

- Benefits terminate on the last day of the month in which your employment terminates.
- Information regarding your COBRA rights is mailed to your home.

Life insurance continuation options are offered. You will be notified by the carrier of your portability/ conversion options and will have up to 45 days to request portability/conversion.

If your employment is reinstated within 30 days or less, there will be no break in coverage. If your break in employment is greater than 30 days, you will be treated as a New Hire.

YOUR QUESTIONS

If you have questions regarding your **eligibility, enrollment, life event changes or unresolved claim issues,** contact the Franklin County Benefits & Wellness Office. The Benefits & Wellness Office is located on the 25th floor of the Franklin County Government Tower at 373 S. High Street, Columbus, OH, 43215 and is staffed Monday through Friday, 8am to 5pm EST. Walk-ins are welcome! Resolution of a claim issue is best handled by the carrier. Contact information for our current carriers is listed below.

BENEFITS
FRANKLIN COUNTY BENEFITS & WELLNESS OFFICE
614.525.5750
BeWell.franklincountyohio.gov/Benefits/Programs
EMAIL: **Benefits@franklincountyohio.gov**

THRIVEON
FRANKLIN COUNTY BENEFITS & WELLNESS OFFICE
614.525.3948
BeWell.franklincountyohio.gov/ThriveOn/Programs
EMAIL: **ThriveOn@franklincountyohio.gov**

ONLINE ENROLLMENT SYSTEM
WEX
614.525.5750
fccBenefits.com
App: Benefitsexpressway

WELLNESS
OHIOHEALTH EMPLOYER SOLUTIONS
1.888.255.0162
fccThriveon.com
App: WebMD Health Services

EMOTIONAL WELLBEING SOLUTIONS
OPTUM
1.800.354.3950
liveandworkwell.com
Access Code: EAP

MEDICAL
UNITED HEALTHCARE
1.877.440.5983
myUHC.com
App: UHC

BEHAVIORAL HEALTH
OPTUM
1.800.354.3950
liveandworkwell.com
Access Code: EAP

PHARMACY
OPTUMRX
1.855.312.2307
OptumRx.com
App: OptumRx

FAMILY BUILDING
MAVEN
mavenclinic.com/join/franklincounty
App: Maven Clinic

DENTAL
AETNA
1.877.238.6200
aetna.com
Text "DENTAL" to 90156
App: Aetna

VISION
VSP
1.800.877.7195
vsp.com
App: VSP

LIFE INSURANCE
THE STANDARD
800.378.4668 for General Questions
OR
800.628.8600 for Life Insurance Claims

DISABILITY
METLIFE
1.866.729.9201
MetLife.com/MyBenefits
App: MetLife US App

LEGAL
METLIFE
1.800.821.6400
members.legalplans.com
App: MetLife Legal Plans

FSA
WEX
1.866.451.3399
Fax: **866.451.3245**
fccBenefits.com
EMAIL: **customerservice@wexhealth.com**
App: Benefits by WEX

COBRA
WEX
1.877.837.5017
mypremiumbill.com
HELP EMAIL: **help@mybenefitexpress.com**

EMOTIONAL WELLBEING SOLUTIONS (FORMERLY EAP)

Staring January 1, 2024, the Employee Assistance Program (EAP) will take on a new name, but you will have access to all of the same services. **What was known as EAP will change to Emotional Wellbeing Solutions or EWS**. Your confidential Behavioral Health and EWS benefits give you access to care, as well as resources and tools to help keep life balanced.

Franklin County Cooperative employees can call the EWS even if they aren't enrolled in the medical plan. The EWS is also available to household members. When you call Optum EWS, you'll speak with a master's-level specialist who can offer in-the-moment support and connect you to other resources, such as in-person counseling sessions, if needed.

Call **1-800-354-3950**, TTY **711**
An EWS specialist will provide an authorization code.

Visit
liveandworkwell.com
Access code: **EAP**

Say Hello to Support
See the behavioral health and EAP benefits available.

AVAILABLE EMOTIONAL WELLBEING SOLUTIOINS

FACE-TO-FACE AND VIRTUAL COUNSELING

Eight visits per problem, per year. A network of clinicians — part of our larger network of 150,000 clinicians — provide goal-oriented counseling.

DIGITAL SELF-CARE TOOLS

Visit **liveandworkwell.com** to access our digital suite of tools and resources, including Talkspace and the Self Care by AbleTo app. Discover the solutions and clinical techniques that best fit your needs to help manage stress, anxiety, and other concerns all in one convenient location.

WORKLIFE SERVICES

Find support for parenting, childcare, eldercare, chronic conditions, and convenience services like pet care. WorkLife specialists can supply educational materials and **no-cost referrals** to verified resources.

FINANCIAL COACHING FROM EXPERTS

Up to 60 minutes of free consultation (provided in 30-minute increments) with a credentialed financial coach for each financial issue. Access to extensive legal and financial tools and libraries to help you take control of your finances.

LEGAL COUNSELING AND MEDIATION SERVICES

Free 30-minute telephonic or in-person consultation with a state-specific attorney or qualified mediator per separate legal issue. Ongoing services are provided at 25% below the firm's current rates after the initial consultation.

EMOTIONAL WELLBEING SOLUTIONS (FORMERLY EAP)

CHOOSE THE SUPPORT THAT WORKS BEST FOR YOU AND YOUR FAMILY

Connect with the **Emotional Wellbeing Solutions** for free, confidential assistance 24/7.	Download the **Self Care by AbleTo** app if you want to explore on your own.
Call the 24/7 **Substance Use Helpline** for concerns about drug or alcohol use.	Build resiliency to better cope with stress through **MeQuilibrium** at **fccThriveOn.com**
Connect with **behavioral health providers** online or in-person.	Get support for your to-do list and maintain your **work-life balance**.
Use 24/7 **Talkspace Online Therapy** for ongoing mental or behavioral health concerns.	Connect to **caring support** from a trained crisis counselor.

Accessing EWS services

1.800.354.3950

Services MUST BE obtained from a network provider.

To locate an EWS clinician, contact Optum at the intake number above or log onto liveandworkwell.com and conduct a provider search. The access code is EAP.

Services MUST BE certified.

To obtain a certification for services, call Optum at the intake number above before visiting your clinician. You may prefer to obtain a certification online at liveandworkwell.com.

Call **1-800-354-3950** or visit **liveandworkwell.com**

Substance Use Treatment Helpline

1.800.780.7955

It's hard to acknowledge that you or a loved one may have a problem. You may feel it's a character weakness that needs to be hidden. But alcohol and drug addiction are a condition, and it's treatable. Seeking treatment is the first important step. But understanding different types of treatment and knowing where to go are just as critical. To help make this process as effective and easy as possible, we have introduced our Substance Use Treatment Helpline program. It's managed by a highly specialized group of licensed clinicians. They are experts in supporting you and your family in getting the appropriate help you need — almost immediately.

Suicide Prevention Hotline

988

If you're thinking about suicide or are worried about a friend or loved one, the Suicide & Crisis Lifeline network is **available 24/7** across the United States. Call or text **988** to be connected to a professional that will provide free and confidential support.

YOUR THRIVEON WELLNESS PROGRAM

The concept of ThriveOn was born out of a need to reposition employee health and wellness in a new light. Rather than approach employee wellness from a "need to improve" perspective, ThriveOn supports a "desire to live well" outlook. A simple shift in thinking can have a huge impact on our motivation. Instead of the message that a person is inherently unhealthy and must work to achieve better health, the ThriveOn program encourages behavior changes made from the desire to live and be well.

Wellness is a lifestyle that is incorporated into every facet of your daily life. Not only physical activity and nutrition, but emotional and environmental health can play just as important of a role in your overall health status. Cultivating a culture of wellness to reach your personal goals transforms something you need to do into something you want to do.

The multi-dimensional approach to ThriveOn seeks to address the variety of factors in one's life that can lead to unhealthy choices. Incorporating these dimensions beyond the physical (what we do, what we eat, etc.), we can effect a deeper change that will further advance our overall health status. Each dimension is unique, therefore, ThriveOn will tailor its programs to reflect the dimension it is addressing.

Some options offered through the ThriveOn Program are:

Health Screening & Assessment, Flu Shots, Incentive Programs, Wellness Challenges, Meal Kit Experiences / Demonstrations, CancerBridge Support, Gym Membership Reimbursement, Health Coaching, Nutritional Support, Health Engagement Nurses, and Tobacco Cessation.

Reach Your Financial Goals with Enrich

Enrich is a personal finance program provided by Franklin County Cooperative & ThriveOn. It is provided at no cost and accessed through your ThriveOn portal under **Wellness Hub**. A full range of resources and support from banking are available to help you create a personalized plan based on your financial goals. Unlimited one-on-one access to financial coaches is also available. Enrich won't market any financial products to you, but they work with you to form a financial plan.

Health Engagement Nurses

As a member of the Franklin County Cooperative, you have access to dedicated Health Engagement through UnitedHealthcare. They can help you:

- Find in-network doctors
- Connect with Orthopedic Health Support
- Make small but impactful changes
- Explore programs and resources
- Discuss options for managing long-term or chronic challenges.
- Navigate United Healthcare tools and services

Your conversations with Therese and Carmen are confidential and at no cost to you. To speak with one of your Health Engagement Nurses, call the Onsite EAP and Health Engagement Nurse Support Line at 614-525-6773.

YellowBird Meal Kits

Participants can receive one free meal kit per year - curated with local produce and ingredients. These meals are delivered right to your door! Participants are then able to watch a virtual cooking demonstration with an OhioHealth dietitian and the owner of Yellowbird Foodshed, cooking a delicious and healthy meal, while learning tips and tricks along the way.

YOUR LIFE INSURANCE

MetLife

Basic Life/Accidental Death & Dismemberment (AD&D)*

Basic Life is group term life insurance that pays a $50,000 benefit if an employee's death results from illness or injury. You are provided this coverage at no cost to you. (Dependents not covered.)

A $50,000 AD&D benefit is also provided at no cost to you and pays an additional benefit for an employee's loss resulting from an accident. The amount payable is a percentage of the $50,000 AD&D benefit, determined by the loss. Examples are provided below. For a full listing of covered losses and corresponding percentages, refer to the life insurance certificate at BeWell.franklincountyohio.gov.

Loss paying a 100% benefit or $50,000:	• Life • Disappearance (if not found in 1 year) • Death due to exposure	• Sight in both eyes • Quadriplegia
Loss paying 50% benefit or $25,000:	• One hand or one foot • Speech • Hemiplegia	• Hearing in both ears • Sight in one eye

THE AD&D BENEFIT ALSO INCLUDES THE FOLLOWING:

Seat Belt Benefit:	$25,000 or 50% of the member coverage amount, whichever is less. AD&D benefit payable for loss of life, if death results from an automobile accident and a seat belt was properly worn at the time of the accident.
Spouse Training Benefit:	25% of member coverage amount or a maximum of $5,000 per year, or the cumulative total of $10,000, whichever is less.
Day Care Benefit:	25% of member coverage amount or a maximum of $5,000 per year, or the cumulative total of $10,000, whichever is less. Maximum duration five (5) years.
Higher Education Benefit:	25% of member coverage amount or a maximum of $5,000 per year or the cumulative total of $20,000. Whichever is less. Maximum duration four (4) years.
Line of Duty Benefit:	$50,000, or 100% of member coverage amount, whichever is less.
Occupational Assault Benefit:	$25,000 or 50% of member coverage amount, whichever is less.
Public Transportation Benefit:	$200,000, or 200% of member coverage amount, whichever is less.

*Some bargaining units and/or agencies may vary in coverage.

YOUR LIFE INSURANCE

You do not need to enroll in the health benefits plan to receive Basic Life/AD&D coverage, but you **MUST** designate a beneficiary on the online enrollment system.

Active at Work Provision

You must be actively at work for coverage to become effective. If you are incapable of active work because of sickness, injury, or pregnancy on the day before the scheduled effective date of insurance, insurance will not become effective until the day after you complete one full day of active work as an eligible employee.

Additional/Supplemental Life

All employees are provided Basic Life and Accidental Death & Dismemberment insurance. You have the option to purchase additional Supplemental Life insurance for you, your spouse/ domestic partner and child(ren). Supplemental Life insurance is a good way to provide additional protection for your family if you (or your covered spouse/child) were to pass away.

Additional (Supplemental) coverage can be requested in the following amounts:

EMPLOYEE	In increments of $10,000 up to a maximum of $500,000 Guaranteed Issue Amount: $100,000
SPOUSE/ DOMESTIC PARTNER	In increments of $10,000 up to a maximum of $150,000 Guaranteed Issue Amount: $50,000
CHILDREN	In increments of $5,000 up to a maximum of $10,000 Guaranteed Issue Amount: $10,000

Things to know about Supplemental Life Insurance:

- Supplemental Life is voluntary group term insurance. You pay 100% of the premiums, which are deducted from your paycheck post-tax.
- Premiums are based on your age and the age of your spouse/partner.

YOUR LIFE INSURANCE

It is important to understand Guaranteed Issue (GI). GI allows you to enroll yourself, your spouse or domestic partner and children without supplying any paperwork or completing any medical application. GI is only available if you are a New Hire or if you experience a Life Event. It is not available during Open Enrollment, so your New Hire Enrollment may be your only chance to take advantage of Guaranteed Issue.

Coverage requests up to the GI amount are automatically approved. Requested coverage over the GI amount must be approved by the life insurance carrier. If you request amounts above the GI, you will be subject to Evidence of Insurability (EOI) and must complete and submit a Medical History Statement form. The application is available on the online enrollment system. The effective date of any coverage above the GI amount is determined by Standard Life.

Guarantee Issue (GI) Examples

New Hire

You request $200,000 for yourself and $100,000 for your spouse during your New Hire enrollment. You are automatically approved for $100,000 and your spouse is automatically approved for $50,000.

The enrollment system alerts you that a Medical History Statement (EOI Form) is required for the amounts above the Guaranteed Issue. You receive written notice from the life insurance carrier upon their decision to either approve or deny the coverage.

Life Event

You are already enrolled for $50,000 Additional (Supplemental) Life and your spouse is already enrolled for $30,000. Congratulations you are the proud parents of a newborn baby boy. Just as you can make changes to your medical coverage within **30 days of a life event**, you are also able to make changes to your life coverage.

You request an increase of $100,000 for yourself and an increase of $70,000 for your spouse. You are automatically approved for an additional $50,000 (A total of $100,000 – which is the GI amount) and must complete a Medical History Statement (EOI Form) to be considered for the remaining $50,000.

Your spouse is automatically approved for an additional $20,000 (A total of $50,000 – which is the GI amount) and must complete a Medical History Statement to be considered for the remaining $50,000. You enroll your son for $10,000 of coverage, all of which is automatically approved.

YOUR LIFE INSURANCE

Open Enrollment, "$10,000 Bump"

You are currently enrolled for $100,000 employee supplemental life. You are not currently enrolled in Spouse Supplemental Life. If you elect to take advantage of the $10,000 Bump, you will be automatically approved for $110,000 employee life on January 1 of the new year. Since you are not currently enrolled in spouse supplemental life, you must complete a Medical History Statement (EOI form) for any election. **The request must be made during your annual Open Enrollment session.**

If you are already at the maximum allowed for employee ($500,000); spouse ($150,000) you are not eligible for any further increases and would not be eligible for the "$10,000 bump".

If you do not have any supplemental life on record, you are not eligible for the GI issue bump up. You may elect coverage, but all amounts elected will required **Evidence of Insurability (EOI).**

Accelerated Death Benefit

This provision provides funds for the terminally ill while still living. It pays 75% of the basic and voluntary term life death benefit in force to a maximum of $500,000. It is available to you, your spouse and your children and allows you to receive a portion of the death benefit during your lifetime, prior to death.

YOUR LIFE INSURANCE

MetLife

Travel Resource Services

You have available 24/7 travel assistance ranging from non-emergency (assistance with obtaining a passport, currency exchange, health hazard advice, and inoculation requirements) to emergency (locating medical care providers, interpreter or legal providers, emergency ticket, passport replacement, emergency evacuation, repatriation, and personal security) services. Travel must be more than 100 miles from home.

US/Canada
1.800.872.1414

Other locations
(collect): +1.609.986.1234
(text): +1.609.334.0807

medservices@assistamerica.com

The Life Services Toolkit

Available to individuals who receive a life insurance or accelerated death benefit, this service provides financial guidance, assistance locating a financial advisor and tips on researching and purchasing different kinds of investments on your own for up to one-year after the beneficiary makes contact for services.

1.800.378.5742

Standard.com/mytoolkit
username: support

Portability and Conversion Options

You have two options to continue your life insurance coverage if you leave County employment or a dependent loses eligibility.

Portability	Portability is group term insurance at a slightly higher premium rate with some restrictions.
Conversion	Conversion is a whole life policy at significantly higher premium rates.

Requests for Portability or Conversion are made to the life insurance carrier and must be made within 45 days of the date you or your dependent(s) loses coverage under the benefit plan. Contact The Standard for rates and forms.

1.800.378.4668

YOUR LIFE INSURANCE

MetLife

Additional/Supplemental Life Monthly Rates

	EMPLOYEE $10,000 increments up to $500,000 – GI amount $100,000	SPOUSE/DOMESTIC PARTNER $10,000 increments up to $150,000 –GI amount $50,000	CHILD(REN) $5,000 increments up to $10,000– GI amount $10,000
Age	**Rate per $10,000 of coverage**		**Rate per $5,000 of coverage**
<25	$.50	$.50	$0.65 Child(ren) rates cover all children in the family. For example, if a $10,000 benefit is elected and there is one child in the family, the monthly deduction is $1.30. If there are 5 children in the family, the monthly deduction remains $1.30.
25-29	$0.60	$0.60	
30-34	$0.67	$0.67	
35-39	$0.72	$0.72	
40-44	$1.00	$1.00	
45-49	$1.50	$1.50	
50-54	$2.30	$2.30	
55-59	$4.30	$4.30	
60-64	$6.60	$6.60	
65-69	$10.34	$10.34	
70-74	$20.60	$20.60	
75+	$20.60	$20.60	

*Rates are based on age as of January 1, 2024.

YOUR LIFE INSURANCE

MetLife

Calculate your monthly cost

	EMPLOYEE	SPOUSE/DOMESTIC PARTNER	CHILD(REN)	
(A) Number of $10,000 increments of Coverage*			$5,000	$0.65
			$10,000	$1.30
(B) Cost per $10,000 of Coverage	x	X		
(A) x (B) = Monthly Cost	=	=		

*Example: The Number of $10,000 increments of coverage for $100,000 of Additional/Supplemental Life coverage is 10.

Add the Employee, Spouse/Domestic Partner, and Child(ren) Monthly Cost to find your Total Monthly Cost for Additional/Supplemental Life coverage.

	+		+		=		
Employee Monthly Cost		**Spouse/DP Monthly Cost**		**Child(ren) Monthly Cost**		**TOTAL MONTHLY COST**	

YOUR DISABILITY PROGRAM

Help protect your financial future should an illness or injury leave you unable to work with Short-Term Disability (STD) and Long-Term Disability (LTD) Insurance coverage underwritten by Metropolitan Life Insurance Company ("MetLife").

Short-Term Disability (STD)	STD replaces a portion of your income during a maternity leave, illness, or injury with a shorter duration.
Long-Term Disability (LTD)	LTD helps replace a portion of your income for extended illness or injury.

Both types of coverage are great ways to get protection against life's unexpected events.

Active at Work Provision

You must be actively at work for coverage to become effective. If you are not Actively at Work on the date insurance would otherwise take effect, insurance will take effect on the day you resume Active Work.

Actively at Work or Active Work means that you are performing all the usual and customary duties of your job at your regular schedule. This must be done at:

- the Policyholder's place of business.
- an alternate place approved by the Policyholder; or
- a place to which the Policyholder's business requires you to travel.

You will be deemed to be Actively at Work during weekends or Policyholder approved vacations, holidays, or business closures if you were Actively at Work on the last scheduled workday preceding such time off.

The disability insurance program offers the following coverage:

Short-Term Disability*

Income replacement provides you with 60% of your gross pre-disability income during a shorter disability. It pays a weekly benefit based upon your gross pre-disability income and provides benefits up to 26 weeks (or 180 days) after a waiting period of 14 days.

Long-Term Disability*

Income replacement provides you with 60% of your gross pre-disability income during an extended illness or injury. After an elimination period of 180 days, it pays a monthly benefit based upon your gross pre-disability income. Benefits are paid up to normal retirement age or Reducing Benefit Duration*.

Combining Short- and Long-Term Disability provides protection that begins almost immediately and can carry you through an extended period. However, there is no requirement that you purchase both products.
You can elect only Short-Term or only Long-Term Disability Insurance.

*100% Employee paid voluntary benefit.

MetLife

TWO WAYS TO SUBMIT A CLAIM:

1.866.729.9201

MetLife.com/MyBenefits

YOUR DISABILITY PROGRAM

MetLife

Policy Provision	Short-Term Disability Insurance	Long-Term Disability Insurance
Elimination Period	14 calendar days from the onset of a disability due to illness, injury or maternity leave	180 calendar days from the onset of a disability or until your Short-Term Disability ends
*An elimination period begins on the day you become disabled and is the length of time you must wait while being disabled before you will receive disability benefits.		
Benefit Amount	60% of your gross weekly pre-disability earnings	60% of your gross monthly pre-disability earnings
*The benefit amount you receive is based upon your gross pre-disability earnings. Your gross pre-disability earnings are the weekly or monthly amount that you earned immediately before you became disabled.		
Maximum Benefit Amount^	$1,500/per week	$10,000/per month
*This is the total amount you will receive in disability benefits. It is a weekly maximum for Short-Term Disability benefits & a monthly maximum for Long-Term Disability benefits.		
Maximum Benefit Duration^^	26 weeks	Greater of Social Security Normal Retirement Age or Reducing Benefit Duration
*This is the total number of weeks during which Short-Term Disability benefits will be paid. For Long-Term Disability, benefits will be paid until normal retirement age or the Reducing Benefit Duration.		

^ Your disability benefit is reduced by other income that you are paid during the same disability from other sources, including state disability benefits, OPERS, no-fault auto laws, sick/vacation pay, etc. **Your agency determines if sick/vacation time must be used prior to disability benefits.**

^^ The Reducing Benefit Duration table is provided in the Certificate of Insurance available from your employer or your MetLife benefits administrator.

The policy certificates are located at: **BeWell.franklincountyohio.gov**

MetLife

TWO WAYS TO SUBMIT A CLAIM:

1.866.729.9201

MetLife.com/MyBenefits

YOUR DISABILITY PROGRAM

Additional Disability Insurance Program Benefits

The disability insurance program provides more than income replacement protection. MetLife offers several return-to-work programs designed to motivate you in your recovery. Your participation in a return-to-work program could also increase your disability payment.

Coverage with Your Best Interest in Mind	Rehabilitation Incentives to Ease Your Burden
Nurse Consultant or Case Manager Services: Specialists who personally contact you, your physician, and your employer to coordinate an early return-to-work plan when appropriate.	Financial Incentive: Allows you to receive disability benefits or partial benefits while attempting to return to work.
Vocational Analysis: Help with identifying job requirements and determining how your skills can be applied to a new or modified job with your employer.	Work Incentive Benefit: Lets you receive up to 100% of your pre-disability earnings including your disability benefit, rehabilitative work earnings, rehabilitation incentives and other income sources.
Job Modifications/Accommodations: Adjustments (i.e., redesign of workstation tools) that enable you to return to work.	Family Care Expense Reimbursement: Reimburses you for eligible expenses (Begins after your 4th weekly benefit payment and pays up to $100 per week) incurred for the care of each qualified family member when working or participating in an approved rehabilitation program.
Retraining: Development programs to help you return to your previous job or educate you for a new one.	Moving Expense Benefit: Provides reimbursement for your move to a different address as part of an approved rehabilitation program.

MetLife

TWO WAYS TO SUBMIT A CLAIM:

1.866.729.9201

MetLife.com/MyBenefits

YOUR DISABILITY PROGRAM

Answers to Some Important Frequently Asked Questions

How is 'disability' defined under the plan?

Generally, you are considered disabled and eligible for disability benefits if, due to pregnancy or accidental injury, you are receiving appropriate care and treatment and complying with your requirements of treatment. In addition:

- Short-Term Disability: You are unable to earn more than 80% of your pre-disability gross earnings at your own occupation.
- Long-Term Disability: You are unable to earn more than 80% of your pre-disability gross earnings at your own occupation for any employer in your local community. Following the Own Occupation period for LTD, you are considered disabled if, due to sickness, pregnancy, or accidental injury, you are receiving appropriate care and treatment and complying with your requirements of treatment and you are unable to earn 60% of your pre-disability gross earnings at any gainful occupation for which you are reasonably qualified considering your training, education, and experience.

Can an employee file for disability while out on maternity leave?

Yes. A 14-calendar day elimination period applies at the beginning of your leave.

What happens to disability coverage if you leave the County?

This is a group policy; therefore, group coverage will end upon employment termination. Only Long-Term Disability Insurance can be converted to an individual policy. Refer to your MetLife certificate for more information.

What if the employee has other sources of income during the disability period?

Your disability benefit may be reduced by the amount of other income that was actually paid to you from other sources during the same disability. This includes payments from state or retirement disability programs, Workers' Compensation, no fault auto laws, sick or vacation pay, etc.

For a complete description of this and other requirements that must be met, refer to the Certificate of Insurance/Summary Plan Description provided by your Employer or contact your MetLife benefits administrator with any questions.

Can an employee still receive benefits if you return to work part time?

Yes. If you are disabled and meet the terms of your disability plan, you may qualify for adjusted disability benefits. Your plan offers financial and rehabilitation incentives designed to help you return to work when appropriate, even on a part time basis, when you participate in an approved rehabilitation program. See Rehabilitation Incentive above.

Are there exclusions for pre-existing conditions?

Yes. Your plan may not cover a sickness or accidental injury that arose in the month's prior to your participation in the plan. A complete description of the pre-existing condition exclusion is included in the Certificate of Insurance available from your Employer or your MetLife benefits administrator.

YOUR DISABILITY PROGRAM

Answers to Some Important Frequently Asked Questions

What is the definition of a pre-existing condition?

A pre-existing condition is a sickness or accidental injury for which you received medical treatment, consultation, care, or services, took prescription medication, or had a medication prescribed, or had symptoms or conditions that would cause you to seek diagnosis, care, or treatment in the 3 months before your disability insurance takes effect.

Benefits for a disability resulting from a pre-existing condition will not be paid until you have been actively at work and covered under the disability insurance benefit for 12 consecutive months after your effective date.

Are there any other exclusions or limitations to coverage?

Exclusions under the plan are standard to most all group disability plans and include disabilities arising from elective procedures such as cosmetic surgery, visual correction surgery, etc. or disabilities resulting from war, participation in a riot or commission of a felony. Long-Term Disability benefits may be limited for mental or nervous disorders or diseases and drug, alcohol, or substance abuse.

A complete description of exclusions and limitations is provided in the Certificate of Insurance available from your Employer at BeWell.franklincountyohio.gov or your MetLife benefits administrator.

HOW DO YOU ENROLL?

You can enroll during New Hire, Life Events, and annual Open Enrollment periods.
Go to fccBenefits.com to begin enrollment.

YOUR DISABILITY PROGRAM

MetLife

The worksheet allows you to estimate your approximate monthly and annual contributions for **Short Term Disability (STD) and Long-Term Disability (LTD)** coverage. Actual contributions will be calculated by your applicable payroll system.

Short-Term Disability Insurance		
A	Annual Earnings=	
B	Weekly Earnings= *(A ÷ by 52)*	
C	Weekly Benefits= *(B x 60%)*	
D	Value Per $10= *(C ÷ by 10)*	
E	Enter applicable age-banded rate=	
F	**Estimated Monthly Contribution=** *(C x by column E)*	

Long-Term Disability Insurance		
A	Annual Earnings=	
B	Monthly Earnings= *(A ÷ by 12)*	
C	Value per $100 *(B ÷ by 100)*	
D	Enter applicable age-banded rate=	
E	**Estimated Monthly Contribution=** *(C x by the applicable age-banded rate D)*	

Short-Term Disability Insurance		Long-Term Disability Insurance	
Age	**Rates per $10 Weekly Benefit**	**Age**	**Rates per $100 Monthly Payroll**
Less than 30	$0.295	Less than 30	$0.355
30-39	$0.290	30-39	$0.423
40-49	$0.330	40-49	$0.634
50-59	$0.500	50-59	$0.646
60-64	$0.657	60-64	$0.528
65+	$0.657	65+	$0.386

YOUR LEGAL PROGRAM

Most people think legal help only comes in handy when trouble strikes. The truth is, people turn to attorneys for all kinds of reasons, from negotiating new home contracts to estate planning. And with MetLife Legal Plans, you get access to sky's-the-limit expertise without sky- high hourly attorney fees.

We have partnered with MetLife Legal Plans to give you access to a nationwide network of attorneys. By enrolling in this group legal product, you receive unlimited access to a network of attorneys with an average of 25 years' experience and specializing in a variety of matters. No copays, no deductibles, or claim forms are required when using a network attorney.

By purchasing the legal plan, you also have access to the following services:

- **Plus Parents** - Cover your parents, parents-in-law, and grandparents for many common legal issues – up to 8 additional people.
- You and your family have access to a highly trained Care Team, who can help navigate Caregiving challenges.
- **Reproductive Assistance Law Coverage** - Covered for legal services and court work related to reproductive assistance matters.
- For **Tax Preparation & Filing** MetLife partnered with TurboTax® to offer state and federal tax preparation and filing services. There is no additional cost for any "Do it Yourself" product.
- Your plan covers you for contested or uncontested divorce and we'll help you find a family law attorney.

This program is voluntary. Employees pay 100% of the post-tax $16.50 per month premium. By enrolling in this program, you agree to participate for the full plan year.

Example of Services Covered	Cost with Plan	Average Cost Without Plan
Legal Contract Review	$0 Out of pocket	$100-$350 per hour
Traffic Ticket Defense	$0 Out of pocket	$100-$350 per hour
Will, Living Will, Power of Attorney	$0 Out of pocket	$100-$350 per hour
Total Premium Cost	**$198 per year**	

YOUR FLEXIBLE SPENDING ACCOUNT (FSA)

What is an FSA?

Flexible Spending Accounts (FSA) are **optional** programs that allow an employee to set aside pre-tax dollars from their regular earnings to pay for qualified expenses (linked HERE) related to health and dependent care costs. There are two types of FSAs available (Healthcare FSA and Dependent Care FSA). You can enroll in one, both or neither program. Your annual election determines how much pre-tax money is taken from your pay and deposited into your FSA. If you are a benefits eligible employee, you are eligible to participate in the FSA plans. You do not need to be enrolled in the health plan.

To participate in the dependent care FSA (DCFSA), a few additional IRS imposed requirements also apply.

- You are unmarried, OR
- Your spouse works, is actively seeking work, is a full-time student, or is disabled and incapable of self-care, OR
- You are divorced or legally separated and have custody of your child(ren) even though your former spouse may claim the child(ren) for income tax purposes. Expenses associated with the childcare services provided for the period the child resides with you are reimbursable.

HEALTHCARE FSA (USED TO PAY FOR HEALTHCARE)	DEPENDENT CARE FSA (USED TO PAY FOR DEPENDENT CARE, NOT HEALTHCARE)
Maximum election: $3,200 You may use this account to pay for health and medical-related care for you and your dependents.	**Minimum election: $120** **Maximum election: $5,000 per family ($2,500 if filing separately)** You may use this account to pay for qualifying dependent care expenses, such as daycare, preschool, or elder care. This account may not be used to cover dependent health or medical-related care.

Fund Availability

The total dollar amount you elect for **Healthcare FSA** is available to you on January 1; any funds rolled over from the previous year will be available to you beginning April 1. **Dependent Care FSA** dollars are available to you as they are deducted from your paycheck and deposited into your FSA account. Use the FSA Benefits Card as you would a banking card. Swiping or charging an eligible transaction automatically removes funds from your FSA account and pays the vendor. You may be required to provide supporting documentation, so it's important you save any accompanying receipts and paperwork.

YOUR FLEXIBLE SPENDING ACCOUNT (FSA)

Use it or Lose it

The IRS governs FSA programs and a 'Use It or Lose It' rule applies. Keep this in mind when making your FSA elections for the plan year. This rule states that any funds remaining in your FSA account at the end of the runout period are forfeited, with the following exceptions:

- **Runout Period:** Allows you to submit claims through March 31 of the following plan year for expenses that were incurred during the previous plan year. Must be submitted via manual claim form.
- **Healthcare FSA Carryover (Rollover):** Carryover allows you to rollover up to $640 of your remaining Healthcare FSA balance from the current plan year into the following plan year Healthcare FSA, **after all eligible claims have been submitted by the March 31** runout deadline. Unlike a Grace Period, you have the entire year to spend the amount of the Carryover.
- **Dependent Care FSA Grace Period:** Allows you to use your remaining Dependent Care FSA balance for expenses incurred through March 15 of the following plan year. **After the grace period unspent Dependent Care FSA dollars are forfeited and will not be returned to you.**

Scan the QR Code or head to **www.screencast.com/t/cTyFX4MRt** to learn more about your Healthcare FSA.

YOUR MEDICAL

UnitedHealthcare

Your medical plan is United Healthcare's **Choice Plus PPO** – a Preferred Provider Organization – which provides coverage for both in-network and out-of-network providers. Your out-of-pocket expense is lower if you use an in-network provider; however, if you wish to seek benefits outside of the network, you still receive comprehensive benefits.

Participation in the annual ThriveOn Program may reduce your out-of-pocket expenses. If you complete the Reduced Deductible incentive, you are enrolled in the Incented plan. If you do not complete the Reduced Deductible incentive, you are enrolled in the Standard Plan. The tables below reflect your in-network coverage only. For out-of-network coverage, review Summary of Benefits and Coverage (SBC) and/or Summary Plan Description (SPD).

	STANDARD	INCENTED
	SERVICES SUBJECT TO THE DEDUCTIBLE, THEN COVERED 100% See services listed below	
Single Deductible	$500	$200
Family Deductible	$1,250	$500
Coinsurance	100% Covered	100% Covered
Single Out-of-Pocket Maximum	$2,500	$1,000
Family Out-of-Pocket Maximum	$6,250	$2,500

Major Diagnostic: CT scans, PET scans, MRI, Nuclear Medicine, etc.

Other Services subject to the deductible:

Outpatient surgery	Inpatient hospitalization
Major diagnostics	Durable medical equipment
Prosthetic devices	Medical supplies
Hearing aids	Home health care
Skilled nursing facility	Inpatient rehabilitation
Transplantation services	Fertility services

Do copays apply to the deductible?	No
Do copays apply to the Maximum Out-of-Pocket?	Yes
Does the deductible apply to the Maximum Out-of-Pocket?	Yes

Amounts applied to the medical deductible and MOOP will also be applied to the behavioral health deductible and MOOP and vice versa.

A complete description of the medical plan benefits, limits and exclusions can be found in the Summary Plan Description at BeWell.franklincountyohio.gov

YOUR MEDICAL

UnitedHealthcare

CHOICE PLUS PPO

In-Network*

SERVICES SUBJECT TO A COPAY

Includes physician office visits, urgent care, emergency care, therapies, and chiropractic care

Primary Care Physician Office Visit

Includes Family and General Practitioner, Internist, Pediatrician and OB/GYN

Preventive Care: $0	**Non-Preventive Care:** $20
Includes routine physical, annual gynecological and well childcare exams	Includes any office visit with a 'diagnoses' noted on the claim submission

Specialist Office Visit in the following specialties

Tier 1 Premium: $20
Non-Tier 1 Premium: $40

Allergy Cardiology	Endocrinology	Orthopedics –
Cardiology	General Surgery	Hand, Foot/Ankle
Electrophysiology Cardiology Interventional	General Surgery – Colon/Rectal	Hip/Knee Shoulder/Elbow Spine
Cardiothoracic	Nephrology	Sports Medicine
Surgery	Neurology	Pulmonology
Ear, Nose and Throat (ENT)	Neurosurgery - Spine	Rheumatology Urology
	Ophthalmology	

All Other Specialist Office Visits: $20

Therapy/Rehab: $20 Physical/occupational/speech/pulmonary rehab
Limited to 25 visits per year for each therapy/rehab type.
Unlimited visits per year for post-cochlear implant aural therapy
Cardiac rehab limited to 36 visits per year.

Massage Therapy and Acupuncture: $20
Limited to 15 visits per year

Chiropractic Care: $20
Limited to 25 visits per year
First three visits $0 copay for newly diagnosed back pain

Kaia: $0
Available 24/7

Urgent Care Copay: $25

Emergency Room Copay: $150
Applies to ER/Observations (Waived if admitted)

*For Out-of-Network coverage, see the Summary of Benefits and Coverage (SBC)

YOUR MEDICAL

UnitedHealthcare

CHOICE PLUS PPO

In-Network*

SERVICES COVERED 100%

Includes Preventive Care, Minor Diagnostic Services, and In-Office Surgical Procedures

Preventive Care: 100%

Routine physical and well childcare exams and immunizations

Women's Preventive Care: 100%

Well woman exam, i.e., annual gynecological exam (including preconception counseling and prenatal care)
Prenatal care (Delivery and high-risk prenatal services are covered but not under Women's Preventive Care)
Breast feeding support, supplies (including rental or purchase cost if obtained from a network physician, hospital or durable medical equipment (DME) provider) and counseling.
Contraception methods (including Mirena, Implanon, Nexplanon, Paragard IUDs, Depo Provera injections, diaphragm, Femcap and Tubal Ligation)
Screenings for Domestic Violence, Gestational Diabetes, and Human immune-deficiency virus (HIV) screening/counseling.
Human papillomavirus (HPV) testing (beginning at age 30 and every 3 years thereafter)
Sexually transmitted infection counseling.
Mammogram and Digital Breast Tomosynthesis (DBT)/3-D
Pap Smear

Nutritional Counseling: 100%

Unlimited visits at a United Healthcare in-network dietician or nutritionists

Minor Diagnostic: 100%

Minor x-rays, blood draw, lab work, EKG, EEG, ultrasound, etc.

Surgical Procedures in a Physician's Office: 100%

Examples include mole removal, stitches, casts, etc.

Therapeutic: 100%

Chemotherapy, dialysis, radiation oncology, IV infusion, etc.

Virtual Visits: 100%

See and talk to a doctor from your mobile device or computer proficiency

****Diabetic Pumps and Supplies:** 100%

Diabetic supplies and pumps purchased through the medical plan is covered 100%

* For Out-of-Network coverage, see the Summary of Benefits and Coverage (SBC)

** Refer to Pharmacy Coverage for purchases through pharmacy

UnitedHealth Premium Program

The UnitedHealth Premium Program recognizes physicians and facilities meeting or exceeding guidelines for quality and cost-effective care and encourages you to use this information to make an informed choice when selecting a provider.

The program uses evidence-based medicine and national standards to evaluate quality. Cost efficiency standards rely on local market benchmarks for the efficient use of resources in providing care.

Physicians in 22 specialties can receive a Tier 1 Premium designation. If your physician practices in one of the specialties below and is rated a Tier 1 Premium provider, your copay will be less than providers not rated Tier 1. To find out the designation of your physician, go to **myUHC.com** or **mychoicenotchance.com**.

Allergy	Cardiology	Cardiology Electrophysiology & Interventional	Pulmonology
Cardiothoracic Surgery	Ear, Nose and Throat (ENT)	Endocrinology	General Surgery
General Surgery – Colon/Rectal	Nephrology	Neurology	Neurosurgery – Spine
Ophthalmology	Orthopedic	Rheumatology	Urology

Your copay for specialty care outside of the specialties listed above and for Primary Care Physician services (General and Family Practitioner, Internal Medicine, Pediatrician and OB/GYN) is $20 regardless of designation.

Personal Health Support

Facing a long-term chronic illness or other complex health issue can take a huge toll on you and your family. With Personal Health Support, you have 24/7 access to a team of registered nurses dedicated to Franklin County Cooperative members to provide extra support every step of the way. Tailored to your specific situation, your nurse helps you take full advantage of the resources already available to you, gives you tips for working with your health care providers more effectively, tells you about additional services that may be helpful and answers questions about your specific health concerns. Personal Health Support is voluntary and you and your nurse work to establish the level of support that you want and need. You may contact Personal Health Support directly by calling the telephone number for members on the back of your United Healthcare ID card. A nurse may also contact you if you have an existing chronic health condition, such as asthma, diabetes, or coronary artery disease or if you have had a recent or are expecting a future hospitalization.

YOUR MEDICAL

UnitedHealthcare

Nurseline

Nurseline provides access to registered nurses, day, or night, to help you make healthcare decisions.

These nurses are an excellent resource when you need help choosing care, understanding treatment options and more. Nurseline also provides access to an audio health information library with over 1,100 health and well-being topics.

Disease Management

Disease Management is designed to help members improve self-care, identify warning signs and access resources for assistance, with the goal of reducing the need for urgent/emergency services. The Disease Management program:

- Reinforces and supports physician treatment plans.
- Helps members prepare for physician visits so they get the most out of their care encounters.
- Helps eliminate unnecessary or redundant procedures, reduce complication rates, and improve medical outcomes.

This program includes assistance for:

- Asthma
- Chronic Obstructive Pulmonary Disease (COPD)
- Coronary Artery Disease (CAD)
- Diabetes
- Congestive Heart Failure (CHF)
- Cancer Bridge

Cancer Resource Services

Nurses that specialize in cancer treatment help you understand your cancer diagnosis, available treatment options, and where you can seek treatment for your specific cancer. Gain access to some of the nation's leading cancer centers by:

1.866.936.6002

myUHC.com

Kidney Resource Services

Kidney Resource Services provides access to a Centers of Excellence network of top-performing dialysis centers and nurse consulting services to support the management of kidney diseases. Dialysis patients who are candidates for kidney transplantation can also access the Transplant Centers of Excellence network.

1.888.936.7246

myUHC.com

Congenital Heart Disease (CHD) Services

Congenital heart defects are the number one cause of death for children from a birth defect during the first year of life. Treatment usually involves complex surgical interventions. This program provides information and access to the CHD Centers of Excellence network, and gives patient's care that is planned, coordinated, and provided by a team of experts who specialize in treating CHD. Nurses help you find a network medical center for specialized care.

1.888.936.7246

myUHC.com

Transplant Resource Services

The Transplant Centers of Excellence network is the nation's leading network and includes only transplant programs that have met strict criteria for transplant excellence. Nurse consultants provide the information you need to make informed decisions about transplant care.

1.888.936.7246

myUHC.com

UnitedHealth Allies

UnitedHealth Allies offers discounts at certain health care providers of medical services that are not covered by your health care benefits. It does not make payments to the provider but offers discounts for the following products and services:

- Cosmetic Dentistry
- Alternative Care
- Wellness (Acupuncture/Massage) (Naturopathy)
- Vitamins and supplementals
- Long-Term Care Services (Assisted living services)
- Laser Vision Correction (LASIK)
- Alternative Care (Health club membership fees, Nutrition services, Weight management programs)
- Health and Wellness Retailers (Fitness apparel and equipment, Aromatherapy, nutrition, and natural foods)

2nd MD

A second opinion program that engages medical experts from across the nation to provide peer-to-peer consultation with local providers. A medical expert connects with your provider. Together they review your diagnosis and recommended treatment plan and discuss alternative options, when appropriate. It does not intend to deny you care or prevent treatment. It does provide you peace of mind and confidence in your next steps in your care plan. Your engagement with 2nd MD is 100% voluntary and if alternative treatment is proposed, there is no requirement to follow the advice of the medical expert.

1.888.936.7246

myUHC.com

UnitedHealthcare

Orthopedic Health Support

Orthopedic Health Support (OHS) is an exclusive end-to-end approach to Musculoskeletal care (MSK). OHS assists with a wide range of MSK issues, from hands to backs.

The MSK Care Continuum is illustrated to the right. The top illustrates the most conservative care. As you travel further down the continuum, the care becomes more invasive and, in many cases, leads to surgery. OHS provides advocacy and coaching throughout the entire MSK Care Continuum. It is not intended to replace or contradict your relationship or advice from your physician. But it will connect you with orthopedic nurses who can meet you where you are on the continuum, discuss treatment options and benefits available under your plan, provide holistic advocacy pre- and post-surgery, and talk about the importance of selecting a provider of high quality.

Members who receive surgery at a Center of Excellence (COE) facility will receive a $500 incentive. OHS will assist in directing members to a COE facility when available.

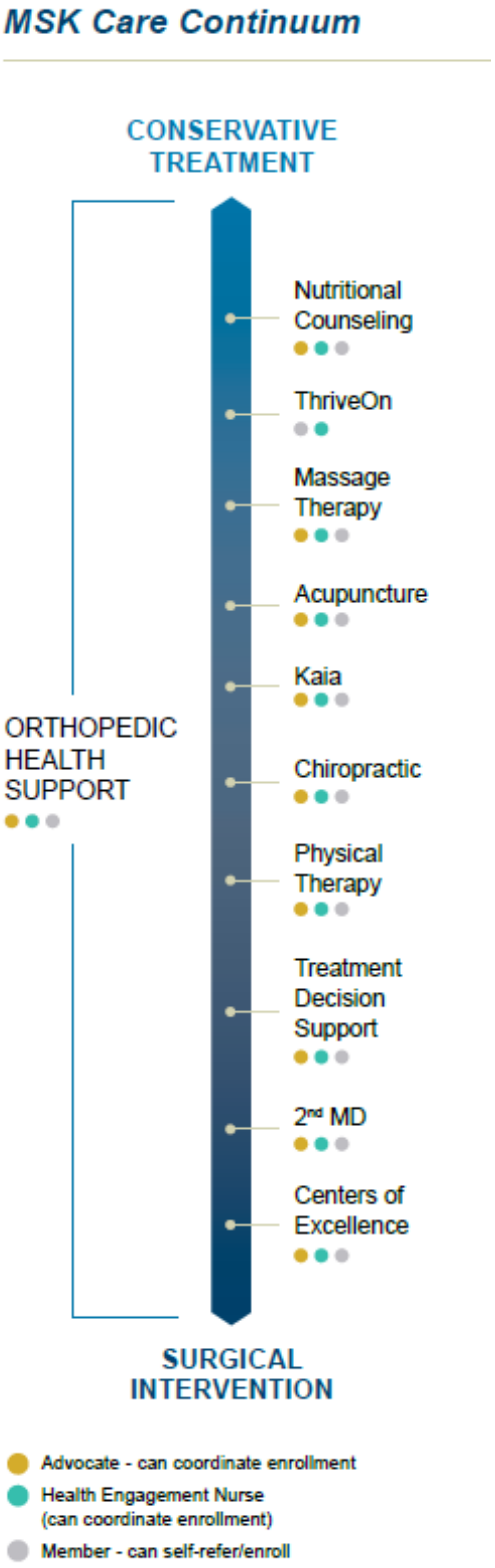
1.888.936.7246

myUHC.com

Participation in OHS is voluntary but is very strongly encouraged. Members can self-refer into the program or OHS may reach out to you and invite you to enroll.

OHS manages a full range of orthopedic conditions:

- Knee/hip
- Disc repaid/spinal fusion
- Shoulder
- Carpal tunnel
- Elbow hand
- Ankle/feet



Bariatric Resource Services (BRS)

Bariatric surgery is a serious, life-changing medical procedure that should be considered as a final step in one's weight loss journey. Coverage for Bariatric Surgery is only available at a network Center of Excellence (COE) facility.

Optum Bariatric Resource Services (BRS) provides you with access to a team of clinical experts who specialize in weight loss and bariatric surgery. Bariatric Resource Services nurses can help you learn about your surgical options, meet your pre-surgical requirements, and find high quality Center of Excellence (COE) network providers, it also provides support for members, their family members, and caregivers, increasing the potential for success. Enrollment in BRS is voluntary but very strongly encouraged.

1-888-936-7246, TTY 711

myUHC.com

Gender Dysphoria

Gender Dysphoria refers to psychological distress that results from an incongruence between one's sex assigned at birth and one's gender identity. Treatment of Gender Dysphoria includes a multidisciplinary approach involving medical, pharmacy, as well as behavioral health services. Coverage includes psychotherapy, continuous hormone replacement, surgery to change the genitalia and specified secondary sex characteristics, breast augmentation, voice/speech therapy/training, tracheal shave, and facial feminization. Specific and stringent qualifications must be met to qualify for services, including completing at least 12 months of continuous hormone therapy without contradictions, and at least 12 months of successful continuous full-time, real-life experience in the desired gender. The treatment plan must conform to identifiable external sources, including the World Professional Association for Transgender Health Association (WPATH) standards and/or evidence-based professional society guidance. Surgery is subject to the deductible. Standard copays apply for office visits.

YOUR BEHAVIORAL HEALTH

If services beyond those provided by the EWS are needed and you are enrolled in the benefit package, your behavioral health benefit 'kicks in'. The network of EWS clinicians is also the network of behavioral health clinicians, so care continues with the same clinician.

Plan Provision	United Behavioral Health	
	Standard	Incented
Annual Deductible	None	
Coinsurance	Plan pays 100%, You pay 0%	
Maximum Out-of-Pocket (MOOP)	Individual: $2,500 Family: $6,250	Individual: $1,000 Family: $2.500
Outpatient	100% coverage for the first 30 visits/telemedicine $20 copay for additional visits beyond the first 30 days Copay is waived for "Other" services, including but not limited to Intensive Outpatient Program and Applied Behavior Analysis (ABA).	
Inpatient	100% coverage for inpatient treatment for mental health or substance abuse	
Do copays apply to deductible?	No	
Do copays apply to the MOOP?	Yes	
Does the deductible apply to the MOOP?	N/A	

Amounts applied to the medical deductible and Maximum Out-of-Pocket (MOOP) will also be applied to the behavioral health deductible and Maximum Out-of-Pocket (MOOP) and vice versa.

*For Out-of-Network coverage, see the Summary of Benefits and Coverage (SBC)

Accessing Behavioral Health services

If treatment transitions from EWS to in-network behavioral health, you or your provider **MUST** contact Optum. The intake number is printed on the back of your United Healthcare medical ID card. If you are accessing an out-of-network provider for treatment, authorization is recommended prior to services being rendered.

MEDICAL AND BEHAVIORAL HEALTH VIRTUAL VISITS (VV)

As lives become more hectic and appointment times with doctors become less available, telemedicine has become a growing trend in health plans. Your telemedicine option is called 'Virtual Visits' ("VV"). Look at the table below to learn more about your virtual visit options for Medical and Behavioral Health.

Plan Provision	Medical VV	Behavioral Health VV
Where do I begin?	myUHC.com or Health4Me app Find a doctor > Services & Treatments > Office Visits > Virtual Visits	liveandworkwell.com Find a resource >liveandworkwell.com Virtual Visits
Do I need to register a username and password on the website to use VV?	Yes	Yes
What is my cost for a VV?	$0	$0
When should I use VV?	For minor illness: Allergies, pink eye, bladder infection, cough/cold, sinus problems, diarrhea, seasonal flu, stomachache, prescription medications (per state rules)	For general concerns: Depression, anxiety, general therapy, prescription medications (per state rules)
What equipment or technology do I need?	High speed internet connection (cable, DSL), desktop/laptop/tablet/mobile device with camera/video capability	High speed internet connection (cable, DSL), desktop or laptop (some providers support use of tablet/mobile device) with camera/video capability
Who can use this service?	Anyone covered by your health plan	Anyone covered by your EAP/behavioral health plan
How quickly do I receive services?	Typically, within an hour	Typically, within 1 week Within 5 business days if using an Express Access Network provider (identified by stopwatch icon)

VV for medical certainly cannot replace your primary care physician but can provide an alternative when seeking care for an immediate, minor illness. VV for behavioral health promises the same standard of treatment and outcome as you would receive with a face-to-face visit with a clinician. It is an alternative option that provides timely, easy access without the stigma that some feel by visiting an actual clinician's office.

If you have questions about either option, please contact your Health Engagement Nurse or the Benefits & Wellness Office.

YOUR PRESCRIPTION DRUG

Optum Rx®

Your prescription drug plan encourages the use of the most cost-effective prescription drugs whenever appropriate. Your copays are lower for Tier 1 medications and programs, such as Step Therapy, assist in finding lower cost, equally effective alternatives when appropriate.

Over the counter (OTC) medications (Proton Pump Inhibitors (PPIs) and Other Preventive Care Medications) are covered by the plan as indicated below. Over-the-counter medications are not available through mail order. To receive coverage for an over-the-counter medication, you must have a written prescription from your physician. Present the OTC medication, the written script and your OptumRx identification card to the pharmacy counter.

A $4,000 individual and $10,000 family Maximum Out-of-Pocket limit applies to pharmacy coverage. If your out-of-pocket prescription drug expenses reach $4,000, 100% coverage will be applied during the remainder of the plan year.

NON-SPECIALTY MEDICATIONS			
Category	Retail Up to a 30-day supply	Retail 60-day/90-day supply	Mail Order Up to a 90-day supply
Tier 1	$5	$10/$15	$12.50
Tier 2	$25	$50/$75	$62.50
Tier 3	$50	$100/$150	$125
Brand with Generic Available	$50 +	$100+/$150 +	$125 +
PROTON PUMP INHIBITORS (PPIs)			
Category	Retail Up to a 30-day supply	Retail 60-day/90-day supply	Mail Order Up to a 90-day supply
Tier 1	$5	$10/$15	$12.50
Tier 2	$75	$150/$225	$187.50
Brand with Generic Available	$75+	$150/$225+	$187.50+
Antihyperlipidemic (Cholesterol Medication)	$0	$0	$0
Anticoagulants (Blood Thinners)	$0	$0	$0

+ Plus, price difference between brand and generic, or the cost of the brand drug, whichever is less.

YOUR PRESCRIPTION DRUG

Optum Rx®

Retail at your Local Pharmacy vs Mail Order through Home Delivery

Both retail and mail order options are available.

Retail	Mail
Get up to a 90-day supply of medication at retail.	90-day supply of medication through mail order and pay a discounted copay.

If you choose mail order, your medications are delivered to your home in a non-descript envelope. Once your prescriptions are established at mail order, you receive a reminder – either an email or a telephone call - when it is time to refill. Pick up the phone to order your refill or go online to OptumRx.com and request a refill. OptumRx covers the cost of standard shipping.

Go to OptumRx.com to learn more about mail order including how to transfer your prescriptions from retail to mail order.

DIABETIC SUPPLIES, INJECTIBLE INSULIN, & ORAL ANTI-DIABETIC MEDICATIONS
Must have written prescription for diabetic supplies.

Category	Retail Up to a 30-day supply	Retail 60-day/90-day supply	Mail Order 90-day supply
Insulin & Supplies: Tier 1, Tier 2, or Tier 3	$0	$0	$0
Continuous Glucose Monitors Tier 1 or Tier 2	$0	$0	$0
Oral anti-diabetic, antihyperlipidemic (cholesterol medication) and anticoagulants (blood thinners) and high blood pressure medications: Tier 1 or Tier 2	$0	$0	$0
Oral anti-diabetic, antihyperlipidemic (cholesterol medication) and anticoagulants (blood thinners) and high blood pressure medications: Tier 3	$50	$100/$150	$125
Brand with Generic Available	$50+	$100+/$150+	$125+

+ Plus, price difference between brand and generic, or the cost of the brand drug, whichever is less.

YOUR PRESCRIPTION DRUG

Optum Rx®

WOMEN'S PREVENTIVE CARE/COVERED 100%

BIRTH CONTROL

- Hormonal: All Tier 1 birth control pills as well as some single source brand name birth control medications
- Transdermal Patch: Ortho Evra
- Emergency: All Tier 1 and Ella

CANCER PREVENTION

- Tamoxifen and Raloxifene (with Prior Authorization)

OTHER PREVENTIVE CARE MEDICATIONS/COVERED 100%

- **Aspirin:** Generic over-the-counter products (to prevent cardiovascular events (for men ages 45 to 79 and women ages 55 to 79)
- **Fluoride:** Generic prescribed products (for preschool children older than 6 months of age through 5 years)
- **Folic Acid:** Generic over the counter and prescribed products (for women ages 18 to 45)
- Iron Supplements: Generic over the counter and prescribed products (for children ages 6 to 12 months at risk for iron deficiency anemia)
- **Smoking Cessation:** over the counter and prescribed products (for men and women ages 18 or older who use tobacco products)
- **Statins:** lovastatin as well as atorvastatin and simvastatin (with prior authorization) (to prevent cardiovascular disease in individuals at high risk)

YOUR PRESCRIPTION DRUG

SPECIALTY PHARMACY

OptumRx Specialty Pharmacy is your exclusive specialty medication mail order pharmacy. Except for a short list of medications that are required for short term use in certain circumstances, specialty medications are not available from your retail pharmacy.

With OptumRx Specialty Pharmacy, you receive personalized medication management, benefit coordination, education materials and social support services. This is particularly important if you are justbeginning treatment with a specialty medication. Your care coordinators are specialty medication experts – in the field of study in which you require for your individual needs – and are available Monday through Friday, 8am to 9pm EST and Saturday, 9am to 1pm EST. If you have an urgent need relating to your medication after hours, a licensed pharmacist is available to assist you.

To get started, call **1.855.427.4682**. A OptumRx Specialty Pharmacy representative verifies benefits, assists with prior authorizations if needed and coordinates the shipment of your medications and any supplies necessary for administration, at no additional cost, to the destination of your choice.

SPECIALTY MEDICATIONS		
Category	Up to a 30-day supply	Up to a 90-day supply
Tier 1	$5	$12.50
Tier 2	$25	$62.50
Tier 3	10% of cost up to $150 per script	10% of cost up to $300 per script

*Note: Only a limited number of specialty medications are available at a 90 day-supply.

Copay Card Accumulator Adjustment Program

Manufacturer coupons, also known as coupon cards, do not apply to your annual out-of-pocket maximum when used for specialty medications.

YOUR PRESCRIPTION DRUG

Optum Rx®

Generic vs Brand

When a company develops a new drug, the FDA provides a period called a drug patent period, where no other company may sell the drug. This allows the original company to recover the investment in the research and development of the medication. But this also eliminates competition and causes the price to remain high. After the drug patent period has expired, other companies manufacture generic versions of the original brand medication. Since the production of generic medication does not require large investments in research, development and advertising, the cost of generics is significantly less than that of brand name medication. All generic drugs must meet the same FDA standards of quality as the brand-name drug.

Generic Equivalent vs Generic Alternative

Brand name drugs may have generic equivalents and generic alternatives.

Generic Equivalent	**A generic equivalent contains the same active ingredient** as the brand name drug. Your pharmacy can substitute the generic equivalent drug in place of the brand name drug without a new prescription.
Generic Alternative	**A generic alternative is a medication that does not contain the same active ingredient** as the brand name but produces the same therapeutic results. Because it is not an exact equivalent to the brand, your pharmacy **cannot** automatically substitute the generic alternative.

Mandatory Generic and Dispense as Written

If a prescription is presented for a brand name medication for which there is a generic equivalent available, the pharmacist is instructed to fill the script as a generic, unless otherwise directed by the member or the prescription. If you or your physician request 'dispense as written' or 'DAW' on the written prescription, the brand name medication is dispensed. This does not, however, lower the copay. If you obtain a brand name medication for which there is a generic equivalent available, you pay the brand name copay as well as the cost difference between the brand and the generic drug. Quite often, you pay the full cost of the drug.

Formulary or Preferred Drug List

Your formulary, also known as a preferred drug list, is a recommended list of brand name and most generic drugs that have been compared and evaluated against other brand-name and generic medications by a committee of physicians, pharmacists, and other healthcare representatives. The drugs on the preferred drug list are chosen because they provide maximum quality and value for your plan and yourself.

It is recommended that you carry a copy of your formulary in your wallet or purse and provide a copy to your physician for your medical file.

Step Therapy

Step Therapy is a program especially for people who take prescription drugs for ongoing conditions like arthritis, high cholesterol, high blood pressure, etc. These drugs are sometimes referred to as maintenance medications. Step Therapy helps the member identify a safe and effective drug to treat the condition while keeping costs as low as possible for both the member and the plan.

STEP THERAPY DRUGS ARE GROUPED IN CATEGORIES:

- **Frontline/first-line drugs (generic and some low-cost brand):** These drugs are proven safe, effective and affordable. Step Therapy requires (with exceptions) that a Frontline/first-line medication be tried first. Why? Because these drugs provide the same health benefit as more expensive drugs, at a lower cost.
- **Back-up drugs (brand):** These drugs are much more expensive to the member in the form of a higher copay and to the plan in higher overall cost. Back-up drugs have not been proven to be any safer or more effective than Frontline drugs.

  Step Therapy requires members who are beginning to take Step Therapy drugs for the first time to try the Frontline drug first.
- **Retail Pharmacy:** If you present a prescription for a Back-up drug at your local pharmacy, the pharmacist alerts you of the requirement to use a Frontline drug first. Your pharmacist may or may not offer to contact your physician's office to discuss your options. It is recommended that you discuss your options with your physician. For the pharmacy to dispense a Frontline medication, your physician must write a new prescription or call in a new prescription to the pharmacy.
- **Mail Order:** Similarly, if you submit a prescription for a Back-up drug at the mail order pharmacy, OptumRx informs you that they cannot fill the script as written. They then reach out to your physician to discuss your options. Again, it is recommended that you contact your physician's office. After multiple attempts, if OptumRx receives no response from your physician's office, the written prescription is returned to you with a letter of explanation.

If there is a medical reason (i.e., allergy to the Frontline drug, tried the Frontline drug before and it didn't produce the desired therapeutic results, etc.) that would prevent you from taking the Frontline drug, your physician should contact OptumRx and request a Prior Authorization.

YOUR FAMILY BUILDING

Every path to parenthood is unique. Physical, emotional, and financial well-being can be impacted when navigating the complexities of trying to build a family. Your health plan offers comprehensive coverage for various family-forming options, including coverage for maternity and fertility services as well as reimbursement for adoption and surrogacy expenses.

Maternity Benefits

Your health plan offers comprehensive maternity coverage with most members paying just the annual deductible for a traditional pregnancy. Coverage is available at both in-network or out-of-network providers. Several support programs are available for expectant families, including the Maternity Support Program and Maven.

Doula Coverage

Doulas play a crucial role in providing comprehensive support to birthing parents throughout the entire childbirth journey, offering emotional, physical, and informational assistance before (antepartum), during (labor and delivery), and after (postpartum) childbirth. Their presence has been shown to significantly reduce negative birth outcomes and enhance the overall birth experience. Your health plan provides two coverage options for doula services:

Maven Virtual Doulas	UHC In-Person Doula Coverage
$0 Cost for Enrolled Members Access virtual doula support through Maven at no cost to you.	**$3,000 Reimbursement** Receive up to $3,000 reimbursement for in-person (or telehealth) doula expenses. You have the flexibility to engage with any certified doula of your choice and submit the necessary information to United Healthcare for reimbursement.

Fertility Treatments

Your health plan covers fertility treatments and fertility medication for covered employees and/or spouses/domestic partners. Coverage is only available if services are received from **in-network** providers.

Medical: Fertility preservation, IUI/IVF, associated donor medical expenses, and egg retrieval/storage	Applicable annual deductibles, coinsurance, and annual out-of-pocket maximums apply and the **combined lifetime maximum benefit for all medical and pharmacy expenses is $30,000 per eligible member**.
Pharmacy: Fertility medication	

YOUR FAMILY BUILDING

Maven Support

Maven is a comprehensive virtual support program tailored to meet the needs of you and your family. It's tailored to complement your maternity and fertility benefits. Maven seamlessly collaborates with your coverage to deliver personalized care throughout the journey from preconception to postpartum. While not mandatory, it is **strongly recommended** that Maven is engaged when utilizing your fertility benefits.

Maven Wallet

Maven Wallet is a reimbursement program. Qualified fertility, adoption, or surrogacy expenses are paid by the member and paperwork (receipts, etc.) are submitted to Maven Wallet for reimbursement. Reimbursement is made through employee payroll. Fertility and Surrogacy reimbursements are treated as taxable income. Certain adoption reimbursements may receive more favorable tax treatment. You must be enrolled in the health plan to receive Maven Wallet and enrollment in Maven is **mandatory**.

Fertility Wallet for the acquisition of donor materials not covered under the health plan including materials obtained from a cryo-bank.	**$10,000 lifetime maximum benefit per household**
Adoption and Surrogacy Wallet for adoption and surrogacy services.	**$30,000 lifetime maximum benefit per household**

Neonatal Resource Services

Nurses that specialize in cancer treatment help you understand your cancer diagnosis, available treatment options, and where you can seek treatment for your specific cancer. Gain access to some of the nation's leading cancer centers by:

1.877.440.5983

Maternity Support Program

A healthy pregnancy is the first step to a healthy baby and mother. The Maternity Support Program is available through United Healthcare and provides personalized support from maternity nurses. The nurses discuss healthy pregnancy habits and provide educational resources throughout the pregnancy. There is no cost to join, and a $200 incentive is available to anyone who enrolls in and completes the program. For more information about the Maternity Support Program, call the number above, also found on the back of your United Healthcare id card.

1.877.440.5983

Enroll in Maven at no cost to you by scanning the QR code, downloading the Maven Clinic app, or visiting mavenclinic.com/join/franklincounty

YOUR DENTAL

Franklin County Cooperative Health Improvement Program offers dental coverage administered through Aetna. The dental DMO (Dental Maintenance Organization) only provides in-network coverage. The dental PPO (Preferred Provider Organization) provides both in-network and out-of-network coverage. The use of in-network providers reduces out-of-pocket expenses. Call 1.877.238.6200 or visit aetna.com to learn more. A full detailed list of the dental services offered under the Aetna Dental DMO plan, and the accompanying fixed copays is available at BeWell.franklincountyohio.gov

You have a choice between TWO dental plan options:

Aetna Dental PPO - A Preferred Provider Organization – provides coverage at both in-network and out-of-network providers. Your out-of-pocket expense is lower if you use an in-network provider. If you use an out-of-network provider, you pay a $25 deductible, a higher coinsurance, and any charges above the reasonable & customary rate.

Aetna DMO - A Dental Maintenance Organization – provides coverage only at in-network providers. If you obtain services from an out-of-network provider, you do not have coverage.

Plan Provision	Aetna Dental PPO		Aetna Dental DMO
	In-Network	Out-of-Network	
Annual Deductible	None	$25 per covered individual	None
Diagnostic Exams, X-Rays	100%	90% after deductible	100%
Preventive Prophylaxis (Cleaning) Adult (Limit 2 per year) Child (Limit 2 per year	100% *(An additional routine cleaning is allowed for expectant mothers)*	90% *(An additional routine cleaning is allowed for expectant mothers)*	100%
Basic Fillings, Endodontics, Periodontics, Sealants, Oral Surgery, Repair of Crowns, Bridgework or Dentures	80%	70% after deductible	Covered at fixed co-pays *See schedule for details*
Major Restorative Crowns, Bridges, Dentures, Implants	80%	60% after deductible	
Annual Maximum Benefit Non-Orthodontic Services	$2,000	$1,500	
Orthodontics	75% Children under 19 only	75% Children under 19 only	Children and Adults Covered at fixed co-pays *See schedule for details*
Lifetime Maximum Benefit (Orthodontic Services)	$2,500 Children under 19 only	$2,400 Children under 19 only	

YOUR VISION

Your vision benefit provides coverage at both in- and out-of-network providers. Your out-of-pocket expense is typically much higher at an out-of-network provider. Network providers also handle the submission of your claim. Out-of-network providers do not. For assistance finding a provider or assistance with out- of-network claims, contact VSP at **1.800.877.7195** or download a claim form at **vsp.com**.

Both the website and the IVR system require your social security number and zip code to generate a list of network providers in your area.

Plan Provision	In-Network	Out-of-Network
Exams	**Every 12 months** $0 copay	**Every 12 months** Reimbursed up to $45
Optomap (Retinal Screening)	**Every 12 months** $20 copay	**Not covered**
Lenses Single Bifocal Trifocal	**Every 12 months** $20 copay for materials for frames and/or lenses. Impact Resistant Lenses covered 100% Members can choose one of the following upgrades with VSP EasyOptions (included in prescription glasses): Fully covered premium or custom progressive lenses, or fully covered light-reactive lenses, or fully covered anti-glare coating.	**Every 12 months** Reimbursed up to $30 Reimbursed up to $50 Reimbursed up to $65
Contact Lenses (Contact lenses provided in lieu of lenses and frames)	**Every 12 months** $180 allowance for contacts Fitting and evaluation capped at $60 and 100% member paid.	**Every 12 months** Reimbursed up to $105
Frames Covered Selection	**Every 24 months** $180 allowance (Retail) $57 allowance (Wholesale)	**Every 24 months** Reimbursed up to $70
Child Frames (Under age 12)	**Every 12 months**	**Every 12 months**

*Necessary contacts are determined at the provider's discretion. Your provider must contact Vision Service Plan prior to the purchase of contacts deemed necessary.

EasyOptions

EasyOptions allows each member to personalize coverage by selecting one benefit upgrade to a 'paid-in-full' option. By visiting a VSP network provider for an exam, you are able to select one of the following upgrades to a 'paid in full' option:

- Anti-Reflective Coating
- Progressive Lenses
- Photochromic Lenses

YOUR VISION

The Diabetic Eyecare Plus Program provides coverage for additional eyecare services specifically formembers with diabetic eye disease, glaucoma, or age-related macular degeneration.

Extra VSP Program Discounts	
Contacts	Contact lens rebates, lens satisfaction guarantees, and more offers at vsp.com/offers.
Glasses and Sunglasses	Average 30% savings on other lens enhancements all non-covered lens options 40% off additional glasses and sunglasses, including lens option, from the same VSP provider on the same day as your WellVision Exam, or 20% discount within 12 months of your last exam.
Laser Vision Correction	Average 15% off the regular price or 5% off the promotional price from contracted facilities. After surgery, use your frame allowance (if eligible) for sunglasses from any VSP doctor.

YOUR COBRA

The Consolidated Omnibus Budget Reconciliation Act (COBRA) requires continuation health coverage is offered to eligible individuals who lost health coverage due to certain specific events. Franklin County Cooperative Health Improvement Program offers COBRA continuation coverage at full cost of coverage plus a 2 percent administrative charge.

COBRA coverage under the Franklin County Cooperative Health Improvement Program includes medical, prescription drug, dental, vision, behavioral health, EWS, and wellness. It does NOT include term life insurance coverage. All eligible employees can elect COBRA coverage for a period of up to 18 months and dependents for up to 36 months.

The qualifying events that cause an employee to lose group health coverage are:

- Termination of the employee's employment for any reason other than gross misconduct
- Reduction in the employee's hours of employment

The following are qualifying events for the spouse, domestic partner, or dependent child of a covered employee if they cause the spouse, domestic partner, or dependent child to lose coverage:

- Termination of employee's employment
- Reduction in the employee's hours of employment
- Death of the employee
- Divorce, legal separation of the employee or termination of a domestic partnership
- Loss of eligibility by an enrolled dependent who is a child
- Spouse or domestic partner becomes eligible for Medicare
- Covered employee becomes entitled to Medicare

For additional information, current COBRA rates, or to initiate the COBRA process call the Franklin County Benefits & Wellness Office at **614.525.5750**.

HOW DO YOU ENROLL?

Log on to the member portal at
mypremiumbill.com

NOTICES & OTHER INFORMATION

SPECIAL ENROLLMENT NOTICE

If you decide not to enroll yourself or your dependents (including spouse/partner) in the Franklin County Cooperative's coverage because you already have coverage through a different provider/ employer, you may be eligible to enroll in the Franklin County Cooperative's coverage later if you lose eligibility through that provider/employer. However, you must contact and request enrollment from the Franklin County Benefits & Wellness Office within 30 days of your or your dependent's current coverage ending.

1095 FORM

You will receive a 1095 form by mail or electronically to show your coverage meets Affordable Care Act (ACA) guidelines. You are not required to provide this form when filing your taxes; however, your tax preparer or advisor may ask to see it.

W-2 HEALTHCARE COSTS

The total cost of your healthcare benefits will be reported on y our W-2. The amount represents both your contribution as well as your employer's contribution. Look for Box 12, 'Code DD'.

WOMEN'S HEALTH & CANCER RIGHTS ACT

The Women' s Health and Cancer Rights Act (WHCRA) of 1998 requires group health plans to make certain benefits available to participants who have undergone a mastectomy. In particular, a plan must offer mastectomy patients benefits for:

- All stages of reconstruction of the breast on which the mastectomy was performed
- Surgery and reconstruction of the other breast to produce a symmetrical appearance
- Prostheses
- Treatment of physical complications of the mastectomy, including lymphedema

Your plan complies with these requirements. Benefits for these items generally are comparable to those provided under the plan for similar types of medical services and supplies. Of course, the extent to which any of these items is appropriate following mastectomy is a matter to be determined by the patient and their physician.

NOTICE FOR NEWBORN MOTHERS HEALTH PROTECTION ACT

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issues may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

MEDICARE PART D NOTICE

As a member of the Franklin County Cooperative, you may have received the Creditable Coverage Disclosure Notice (Medicare Part D) via email in October 2023. You will receive this notice each year you have drug coverage from the health plan. It's recommended that you keep the Creditable Coverage Disclosure Notice (also available at **BeWell.franklincountyohio.gov**). You may need to provide it if you decide to join a Medicare drug plan later. Generally, Medicare is available for people age 65 or older, younger people with disabilities and people with End Stage Renal Disease (permanent kidney failure requiring dialysis or transplant).

HIPAA PRIVACY NOTICE TO EMPLOYEES

The current Notice of Privacy Practices for employees is available on **BeWell.franklincountyohio.gov** and explains your legal rights regarding your protected health information (PHI).

AGREEMENT REGARDING ACCEPTANCE AND REVIEW OF PAYROLL DEDUCTIONS

The tax rate for any "post-tax" payroll deduction will automatically adjust to reflect any applicable tax rate change. It is your responsibility to report any discrepancies with payroll deductions to your human resources office or the Franklin County Benefits & Wellness Office.

NOTICES & OTHER INFORMATION

NOTICE OF EMPLOYER SPONSORED WELLNESS PROGRAM

As part of certain ThriveOn wellness activities you may provide, or the program may gather, private information. Each time you provide personal identifying information or private health information, it will be used only for the purposes for which it is gathered. Your information's privacy will be maintained and protected at all times. Please take a few minutes to read the notice located at the link below to better understand how we protect your information and how we use it. Employees and their eligible family members may choose to take part in this program by completing activities that are listed in the ThriveOn Incentive Brochure (available on **BeWell.franklincountyohio.gov** > ThriveOn > Wellness Your Way). Thank you for trusting us with your information to Employer Sponsored Wellness Program

WHEN A COVERED PERSON QUALIFIES FOR MEDICARE

As permitted by law, this Plan will pay Benefits second to Medicare when you become eligible for Medicare, even if you don't elect it. There are, however, Medicare-eligible individuals for whom the Plan pays Benefits first and Medicare pays benefits second.

- Employees with active current employment status age 65 or older and their Spouses aged 65 or older (however, Domestic Partners are excluded as provided by Medicare);
- Individuals with end-stage renal disease, for a limited period; and
- Disabled individuals under age 65 with current employment status; and their
- Dependents under age 65.

WHO PAYS FIRST?

Coordination of Benefits (COB)

Who pays first when covered by more than one health benefits plan? If coverage is provided under two or more plans, COB determines which plan is primary and which plan is secondary. The plan considered primary pays benefit first, without regard to secondary coverage. Remaining expenses not covered under the primary plan may be paid under the secondary plan. How much this Plan will reimburse you, if anything, will depend in part on the allowable expense.

EXHIBIT 1

Definitions and Required Documents Checklist

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

The required documents must be provided to the Franklin County Benefits & Wellness Office:

- New Hire: Within 30 days of your date of hire
- Qualified Life Event, i.e., marriage, birth, etc.: Within 30 days of the date of the life event
- Open Enrollment: No later than the date specified in your Open Enrollment materials

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

READ THIS ENTIRE CHECKLIST BEFORE YOU ENROLL YOUR DEPENDENTS
☐ Enroll your dependents at fccBenefits.com The enrollment system will indicate your enrollment is pending. Your dependents will be enrolled for coverage upon the Benefits & Wellness Office receiving and approving the required documents.
☐ IMPORTANT: Review your Confirmation Statement for accuracy.
☐ Refer to the dependent types in the following chart. Identify the documents required.
☐ Make Copies of the required documents. Originals are NOT required.
☐ Record the following information in the upper right corner of each document. Employee name and telephone number.
☐ Submit the required documents to the Franklin County Benefits & Wellness Office. Documents must be received within the timeframes illustrated above.

Send documents via post or inner office mail or hand deliver to:	Franklin County Benefits & Wellness Office Franklin County Government Tower 373 S. High Street, 25th Floor Columbus, OH 43215
Fax:	614.525.5515
Email:	Benefits@franklincountyohio.gov
Upload to online enrollment system:	fccBenefits.com

Contact the Franklin County Benefits & Wellness Office if you have questions.

614.525.5750 | Benefits@franklincountyohio.gov

SPOUSE AND DOMESTIC PARTNER		
DEPENDENT TYPE	**DEFINITION**	**REQUIRED DOCUMENT(S)**
Spouse	Legal spouse of a covered employee: Does not include: • Ex-spouse • Legally separated spouse • Common Law Spouse	**ONE (1) of the following OPTIONS for Marriage:** **OPTION 1:** Marriage Certificate (court approved certificate - church-issued certificates are not acceptable or marriage abstract - not license) **PLUS ONE** of the following to show **CURRENT** joint tenancy: • Proof of joint ownership of real estate property; • Proof that covered employee and spouse are both listed on a lease or share the rent of a home or other property; • Joint ownership of a motor vehicle; • Designation of the spouse as a primary beneficiary of the covered employee's life insurance, or retirement benefits; • Utility bill listing both covered employee and spouse (or 2 separate utility bills at the same address, one listing the covered employee and one listing the spouse). **OPTION 2:** Covered employee's most recent Federal Income Tax Return (1040, 1040A or 1040EZ) **as filed with the IRS** listing the spouse: • Page 1 **PLUS** signature page if filed hard copy; **OR** • Page 1 **PLUS** Certificate of Electronic Filing
Common Law Spouse	Common Law spouse of a covered employee as defined by ORC §3105.12.	**The following is the only OPTION for Common Law Marriage:** **THREE (3)** of the following documents to show financial interdependency and joint tenancy. At least one of the documents must date prior to October 10, 1991. At least one must show **CURRENT** financial interdependency and one must show **CURRENT** joint tenancy. • Covered employee's Federal Income Tax Return (1040, 1040A or 1040EZ) **as filed with the IRS** listing the common law spouse; • Proof of joint ownership of real estate property or joint tenancy on a current residential lease; • Joint ownership of a motor vehicle; • Joint liabilities (e.g., credit cards or loans); • A life insurance policy beneficiary designation form designating the common law spouse as primary beneficiary; • A durable power of attorney signed to the effect that the covered employee and the common law spouse have granted powers to one another; • A will designating the common law spouse as primary beneficiary.

SPOUSE AND DOMESTIC PARTNER

DEPENDENT TYPE	DEFINITION	REQUIRED DOCUMENT(S)
Domestic Partner	A qualified domestic partner: • must share a permanent residence with the covered employee; • is the sole domestic partner of the covered employee, has been in a relationship with the covered employee for at least six (6) months and intends to remain in the relationship indefinitely; • is not currently married to or legally separated from another person; • shares responsibility with the covered personfor each other's common welfare; • is at least 18 years of age and mentally competent; • is not related to the covered employee by blood to a degree of closeness that would prohibit marriage; • is financially interdependent with the covered employee in accordance with the plan requirements.	Affidavit of Domestic Partnership **PLUS** **THREE (3)** of the following documents to show at least six (6) months of financial interdependency: • Proof of joint ownership of real estate property or joint tenancy on a current residential lease; • Joint ownership of a motor vehicle; • Joint bank or credit account; • Joint liabilities (e.g., credit cards or loans); • A will designating the domestic partner as primary beneficiary; • A retirement plan or life insurance policy beneficiary designation form designating the domestic partner as primary beneficiary; • A durable power of attorney signed to the effect that the covered employee and the domestic partner have granted powers to one another.

DEPENDENT CHILD		
DEPENDENT TYPE	**DEFINITION**	**REQUIRED DOCUMENT(S)**
Child (up to age 26)	A child of the covered employee.	**ONE (1) of the following OPTIONS:** **OPTION 1:** Covered employee's most recent Federal Income Tax Return (1040, 1040A or 1040EZ) **as filed with the IRS** listing the child as dependent • Page 1 **PLUS** signature page if filed hard copy; **OR** • Page 1 **PLUS** Certificate of Electronic Filing **OPTION 2:** Birth Certificate of child, must include employee's name. **OPTION 3:** Court documents signed by a judge verifying legal custody of the child. **OR** **If one of the OPTIONS above is not available (i.e., when adding a newborn), ONE (1) of the following:** • Hospital release papers on hospital letterhead • Footprints • Crib Card • Letter from physician or hospital on respective letterhead **Documents must include child's DOB and name of parent(s).**
Stepchild (up to age 26)	A child of an employee's eligible spouse, i.e., a stepchild of the covered employee.	**ONE (1) of the following OPTIONS:** **OPTION 1:** Covered employee or spouse's most recent Federal Income Tax Return (1040, 1040A or 1040EZ) **as filed with the IRS** listing the stepchild as dependent • Page 1 **PLUS** signature page if filed hard copy; **OR** • Page 1 **PLUS** Certificate of Electronic Filing **OPTION 2:** Birth Certificate of stepchild, must include eligible spouse's name. **OPTION 3:** Court documents signed by a judge verifying legal custody of the child. If the spouse is not enrolled, documents proving eligibility of the spouse are also required.

DEPENDENT CHILD		
DEPENDENT TYPE	**DEFINITION**	**REQUIRED DOCUMENT(S)**
Domestic Partner Child (up to age 26)	A child of the enrolled domestic partner. The domestic partner must be enrolled in health coverage to enroll the child of the domestic partner in health coverage. The domestic partner must be enrolled in life insurance coverage to enroll the child of the domestic partner in life insurance coverage. *If there is a legal relationship between the employee and the child, i.e., the child was adopted by the employee see the definition below.*	**ONE (1) of the following OPTIONS:** **OPTION 1:** Covered domestic partner's most recent Federal Income Tax Return (1040, 1040A or 1040EZ) **as filed with the IRS** listing the child as dependent • Page 1 **PLUS** signature page if filed hard copy; **OR** • Page 1 **PLUS** Certificate of Electronic Filing **OPTION 2:** Birth Certificate of domestic partner child, must include enrolled domestic partner's name. **OPTION 3:** Court documents signed by a judge verifying legal custody of the child.
Adopted child (up to age 26)	A legally adopted child of the covered employee, spouse, or domestic partner includes children placed in anticipation of a legal adoption. The domestic partner must be enrolled in health coverage to enroll the adopted child of the domestic partner in health coverage. The domestic partner must be enrolled in life insurance coverage to enroll the child of the domestic partner in life insurance coverage.	**ONE (1) of the following OPTIONS:** **OPTION 1:** Covered employee or spouse/domestic partner's most recent Federal Income Tax Return (1040, 1040A or 1040EZ) **as filed with the IRS** listing the child as dependent • Page 1 **PLUS** signature page if filed hard copy; **OR** • Page 1 **PLUS** Certificate of Electronic Filing **OPTION 2:** Court documents for the adopted child from a court of competent jurisdiction **OPTION 3:** International adoption papers from country of adoption **OPTION 4:** Papers from the adoption agency showing intent to adopt If the spouse is not enrolled, documents proving eligibility of the spouse are also required.
Child covered by a QMCSO (up to age 26)	A child for whom health care coverage is required through a Qualified Medical Child Support Order (QMCSO).	**ONE (1) of the following OPTIONS:** **OPTION 1:** Court documents signed by a judge **OPTION 2:** Medical support orders issued by a State agency

GRANDCHILD (I.E) CHILD OF A DEPENDENT CHILD		
DEPENDENT TYPE	**DEFINITION**	**REQUIRED DOCUMENT(S)**
Grandchild	A child of a dependent child. The child must be enrolled in health coverage to enroll the grandchild in health coverage. The child must be enrolled in life insurance coverage to enroll the grandchild in life insurance coverage. *If there is a legal relationship between the employee and the grandchild, i.e., the grandchild was adopted by the employee see the definition above.*	Birth Certificate of grandchild **OR** **If the grandchild's birth certificate is not available**, (i.e., when adding a newborn), **ONE (1)** of the following: • Hospital release papers on hospital letterhead • Footprints • Crib Card • Letter from physician or hospital on respective letterhead **Documents must include grandchild's DOB and name of parent(s).**

DISABLED DEPENDENT		
DEPENDENT TYPE	**DEFINITION**	**REQUIRED DOCUMENT(S)**
Disabled dependent, (age 26 or older)	A dependent incapable of self-sustaining employment because of a mental or physical disability that began while the dependent was eligible.	**ONE (1)** of the required documents for the applicable dependent child definition type above. (SEE DEPENDENT CHILD SECTION) **PLUS** Statement of Dependent Eligibility Beyond Limiting Age Due to Mental or Physical Disability