

Spotlight

BENEFITS & WELLNESS NEWSLETTER

February 2016

MANDATORY Open Enrollment
All employees must confirm benefits
for 2016 or risk benefit termination.

Produced by the Franklin County Benefits and Risk Management Department for members of the Franklin County Cooperative Health Benefits Program

Franklin County proudly continues to offer an outstanding health care program to you and your family, including tools to promote health and help you seek out quality and cost effective health care. But there's more work to be done. Let's do it together.

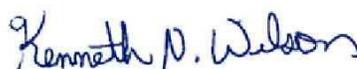
Our health plan has experienced a spike in costs over the past 12 months in part from a number of claims exceeding one million dollars and an increase in catastrophic claims over \$50,000. However, of much more concern is the marked increase in claims for conditions that are preventable, such as diabetes and back injury/surgery. The presence of these *avoidable* claim costs is directly related to how we manage our health. When we practice healthy lifestyles and seek out quality care, these costs go down.

Let's work together to make 2016 our year of health. To reverse course, to improve our health and at the same time the health of the plan. Everyone can make a difference. Here are some suggestions how.

- Take advantage of your preventive care. Schedule an annual routine exam - which is covered 100% by the plan. If you don't have a family doctor, find one. Use the tools at 'Choosing Wisely' (see page 17) to learn the right questions to ask to improve communication with your doctor.
- Shop around and get a second opinion. Ask about alternative treatments. Publications like Consumer Reports provide information about 'shopping' for healthcare because just as washer/dryer sets vary in quality and cost, so can the care received by physicians, outpatient facilities and inpatient hospitals.
- Take advantage of the ThriveOn programs offered. Go to the calendar of activities at <http://bewell.franklincountyohio.gov/thriveon>.
- Avoid the emergency room. Use Urgent Care. Download the Health4Me application from United Healthcare that allows you to easily locate an urgent care. Also check out the Virtual Visit benefit (see page 4) that is new to you on April 1st.

In April, County employees will receive an employee contribution 'holiday'. Your first paycheck in April will have \$0 deducted for your employee contribution. Think of this as the jump start to your 'year of health'. Use toward a pair of walking/running sneakers ... and get out and walk or join a 5k! Use it to pay for transportation to visit a nutritionist ... 100% coverage for nutritional counseling was implemented as part of your health benefits on April 1, 2015. Get a massage to reduce stress, enjoy a sports event with your family, or make a payment to a gym membership ... the choice is yours.

Thank you in advance for taking on this challenge and realizing a 'year of health' for you and your health plan.



County Administrator, Franklin County

2016 MANDATORY OPEN ENROLLMENT



OPEN ENROLLMENT IS MANDATORY!

Open Enrollment begins
Monday, February 8th and
ends Friday, February 26th.
Go to <https://fccbenefits.com>.
Your company key is **fcc**.

Details: Page 3

PAY ONLY 1/2 OF YOUR HEALTH PLAN CONTRIBUTION

In April you will only pay
1/2 of your health care
employee contribution.

Details: Pages 11

AMANDA AND ZACK'S STORY

Should you consider purchasing
disability insurance too? Learn
why Amanda and Zack are.

Details: Page 8



Hello Happy: 2016 is going to be an exciting year for your health!

Here is how you earn points ...	
Activity	Points
Health Assessment & Health Screening	25
<i>Phone Coaching</i>	<i>50!</i>
NEW! Self-Directed Coaching	10
NEW! Digital Workshops	5
Physical Exam	25
Dental Exam	10
Fitness Activity	3
Community Event	5
NEW! Health Education	3
Challenges	10
NEW! Agency Sponsored Wellness Activity	10

More and more of you continue to explore the programs offered through ThriveOn – that’s great! 2016 is going to be very exciting with new programs being offered to help you achieve your personal health goals AND earn an incentive. The Health Risk Assessment will be launching again on March 7, 2016. Health screenings will also be offered again this year. **Those two steps are your starting points for making 2016 your year of health.** Stay tuned for more information from your ThriveOn program.

Amanda Blake
Coordinator of Wellness and Benefits

Hello Happy 2016

You and your spouse/partner earn points by completing healthy activities. Earn 100 points, earn a reward. The reward this year is \$124! That is \$124 for you AND \$124 your spouse/partner.

Watch your home mailbox in March for the postcard shown above. Or if you simply cannot wait ...

- Go to <http://BeWell.franklincountyohio.gov/ThriveOn>
- Log onto <https://fccbenefits.com> for an FAQ (ThriveOn tab)
- Attend an employee meeting
(See schedule on page 22)



READ THIS TO KNOW WHAT TO DO DURING OPEN ENROLLMENT.

Open Enrollment is your opportunity to make changes to your health, life and disability benefit elections for the coming plan year. Changes requested during Open Enrollment are effective April 1, 2016. Open enrollment begins Monday, February 8th and ends February 26th.

Open Enrollment is MANDATORY this year. Even if you do not want to make changes, you must log onto the system and confirm your 2016 coverage. Your current benefit elections will not rollover. If you do not confirm your benefit elections during Open Enrollment, your benefits will terminate March 31, 2016.

An Open Enrollment welcome letter from the Franklin County Cooperative will be mailed to your home. The letter includes the website address as well as other relevant Open Enrollment information. ***If you lose your letter, don't panic.*** Confirm your benefits by following the steps below.

A WORD OF ADVICE: Don't wait until the last minute.

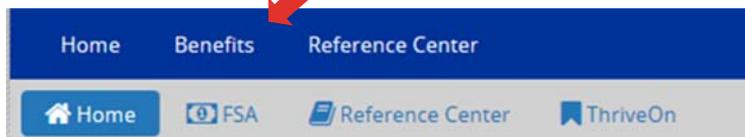
The process is a little different this year. You will be enrolling in a new enrollment system, so you'll need to register a new User Name and Password. The letter that you will receive at home will not include your current benefit elections. You must log onto the new system to review your coverage ... and then decide if you want to change or confirm those benefits for the 2016 plan year.

STEP 1: GO TO [HTTPS://FCCBENEFITS.COM](https://fccbenefits.com)

If you enrolled in the Flexible Spending Account (FSA) program, you would have used this system and already registered a User Name and Password. If you did not enroll in the FSA, then you will need to register a new User Name and Password. Your company key is **fcc** (all lower case).

STEP 2: REVIEW YOUR CURRENT COVERAGE

Click on the **BENEFITS** tab and select **BENEFIT SUMMARY** from the drop down menu. This is a summary of your **current** benefits and contributions. When you have confirmed your 2016 coverage, a **BENEFITS SUMMARY** illustrating your 2016 benefits and contributions will be available. **2016** employee contributions are also referenced on page 20 of the *Spotlight*.



STEP 3: HOW DO I CONFIRM MY COVERAGE FOR NEXT YEAR?

Look for the green apple. Below the apple is a green **START HERE** button. Click the green button. The system will take you from screen to screen until you reach a summary page. Review your coverage and click **APPROVE**. You have not confirmed benefits until you click **APPROVE**.



QR YOURSELF TO THE SIMPLEST OPEN ENROLLMENT YET!

To confirm your benefit elections on your mobile device, simply scan this QR code to quickly access your <https://fccbenefits.com> records.

If you don't have a QR reader/scanner on your mobile device, download one from your app store.



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VIRTUAL VISITS

Access to care - online - 24/7

When you don’t feel well, or your child is sick, the last thing you want to do is leave the comfort of home to sit in a waiting room. A virtual visit lets you see and talk to a doctor from your mobile device (phone or tablet) or computer with camera capabilities.



Conditions commonly treated through a virtual visit

Doctors can diagnose and treat a wide range of non-emergency medical conditions, including:

- Bladder/urinary tract infection
- Migraine/headaches
- Bronchitis
- Cold/flu
- Diarrhea
- Fever
- Pink eye
- Stomach ache
- Rash
- Sore throat
- Sinus problems

No cost to use a virtual visit provider

Your copay for a virtual visit is \$0. You have no out-of-pocket cost.

Safety and confidentiality

All network providers, including virtual visit providers, are required to comply with all laws relating to the security and confidentiality of patient information. Virtual visit providers are covered entities under HIPAA and its regulations. These providers have direct legal requirements to protect and secure confidential patient information.

Why virtual visits?

Illness doesn’t follow a calendar or clock. But your life, provider office and urgent care hours do. If you are unfortunate enough to fall ill ... and fall ill during off-hours ... your options for accessing health care is limited.

Far too often, the emergency room is turned to in these instances. In fact, a large number of Cooperative members visiting the emergency room have a diagnosis of upper respiratory infection, which is basically the common cold or flu. A more appropriate place to access care is a provider’s office or urgent care ... but there’s that pesky calendar and clock again.

When unable to get to a provider’s office or urgent care during office hours, use virtual visits. Virtual visits provide access to physicians 24 hours a day, 7 days a week. Cooperative members and their dependents can see and talk to a provider for non-emergency medical conditions - even receive a prescription.

VIRTUAL VISIT FAQs

Where can I find out what providers are in the virtual visit network and how do I access them?

For information about what virtual visit provider groups are in the network, log onto myuhc.com and conduct a provider search. You can also access the provider groups through the UnitedHealthcare's Health4Me app or by going directly to a network virtual visit provider group's mobile app or website.

What should I consider when choosing a virtual visit provider?

You are able to choose from any of our network virtual visit providers. Some things to consider when choosing a provider are listed here.

- Does the provider group operate and prescribe in the state you are when you need care?
- On average, how much experience do the physicians in the provider group have?
- Do you like the provider group's website and/or mobile app experience? How is the provider's mobile app rated by other consumers?

Some virtual visit provider groups list other services like nutrition counseling, lactation services, therapy and psychology services. Are these covered under my virtual visit benefit?

Not at this time. While you can choose to receive these additional services from a virtual visit provider,

the services will not be covered under your virtual visit benefit and you will be responsible for the full cost.

What happens once I reach the virtual visit provider group's website? What happens during an actual virtual visit?

The first time you use a virtual visit provider you will need to set up an account with that virtual visit provider group. You will need to complete the patient registration process which allows the virtual visit provider to gather medical history, pharmacy preference, primary care physician contact information and insurance information.

Each time you have a virtual visit, you will be asked some brief medical questions, including questions about your current medical concern. If appropriate, you will then be connected using secure live audio and video technology to a doctor. You and the doctor will discuss your medical issue, and if appropriate, the doctor may write a prescription for you.

How long is the wait to see a doctor once I am at the provider group's site? Can I schedule an appointment instead of waiting?

Virtual visit provider groups are expected to deliver care within 30 minutes or less from the time of a patient's request. You are also able to schedule an appointment with a virtual visit doctor.

Will virtual visit information be shared with my Primary Care Physician (PCP)?

We encourage you to provide your PCP information to the virtual visit provider so that virtual visit records can be sent directly to your PCP. You may also be able to access your virtual visit record with the virtual visit provider group, so you can provide the records directly to your PCP or other health care providers as desired.

Am I required to have a PCP in order to use a virtual visit provider?

No, it is not a requirement and you do not need a referral to use a virtual visit.

Can my child or under age dependent use virtual visits?

Yes. A parent or legal guardian must be present when the virtual visit is conducted with a minor dependent. The dependent must be covered under your plan.

If the virtual visit provider writes a prescription for me, how do they get the prescription to my local pharmacy?

Virtual visit doctors use e-prescribing to submit prescriptions to the pharmacy of your choice. (Costs for prescription drugs are payable under your pharmacy benefit.) Not all virtual visits will result in the issuance of a prescription. Prescriptions are provided only when appropriate.

SHORT AND LONG TERM DISABILITY INSURANCE

If you are eligible to enroll in the Cooperative's healthcare plan, you are eligible to participate in the MetLife disability insurance program. The disability insurance program offers the following coverage:

Short Term Disability replaces a portion of your income during the initial weeks of a disability. It pays a weekly benefit based upon your pre-disability income and provides benefits up to 26 weeks (approximately 6 months) after an initial elimination waiting period of 14 days.

Long Term Disability replaces a portion of your income during an extended illness or injury. After an initial elimination waiting period of 180 days (or until your Short Term Disability Insurance benefits end) it pays a monthly benefit based upon your pre-disability income. Benefits are paid up to your 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 of time. However, there is no requirement that you purchase both products. You can elect only Short Term or only Long Term Disability Insurance.

Policy Provision	Short Term Disability Insurance	Long Term Disability Insurance
Elimination Waiting Period	<i>14 calendar days</i> from the onset of the disability due to illness, injury or maternity leave	<i>180 calendar days</i> from the onset of the disability or until your Short Term Disability ends
An elimination waiting 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 <i>weekly</i> pre-disability earnings	60% of your <i>monthly</i> 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. <u>Your gross earnings are your before tax earnings.</u>		
Maximum Benefit Amount**	\$1,500 per <i>week</i>	\$10,000 per <i>month</i>
This is the maximum benefit amount you will receive in disability benefits. It is a weekly maximum for Short Term Disability benefits and a monthly maximum for Long Term Disability benefits.		
Maximum Benefit Duration*	<i>26 weeks</i>	<i>Greater of Social Security Normal Retirement Age or Reducing Benefit Duration</i>
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.		

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

** 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. Workers' Compensation claims are not eligible for short term disability coverage.

Additional MetLife Disability Program Benefits

The disability insurance program provides more than income replacement. 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 Interests in Mind

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.

Vocational Analysis: Help with identifying job requirements and determining how your skills can be applied to a new or modified job with your employer.

Job Modifications/Accommodations: Adjustments (e.g., redesign of work station tools) that enable you to return to work.

Retraining: Development programs to help you return to your previous job or educate you for a new one.

Rehabilitation Incentives to Further Ease Your Burden

Financial Incentive: Allows you to receive disability benefits or partial benefits while attempting to return to work.

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.

Rehabilitation Benefit: Boosts your benefit by up to 10% when you work within a MetLife approved rehabilitation program.

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.

Moving Expense Benefit: Provides reimbursement for your move to a different address as part of an approved rehabilitation program.

CALCULATING YOUR ESSENTIAL LIVING EXPENSES

Every budget has essential and discretionary living expenses. Essential expenses are things like a mortgage or rent payment, the cost of food or utilities. You can't really survive without them. Discretionary expenses can include the cost of a movie ticket, eating out at a restaurant or your daily coffee purchase. If you are unable to work, you can decrease or eliminate your discretionary spending and survive. You must continue to pay your essential living expenses regardless of your ability to earn an income. Disability insurance provides a steady stream of income to pay for essential living expenses, if you become disabled and are unable to work.

EXAMPLE OF ESSENTIAL LIVING EXPENSES

\$ _____	Mortgage/Rent
\$ _____	Car payment
\$ _____	Auto insurance
\$ _____	Credit cards
\$ _____	Loan payments
\$ _____	Child/Elder care
\$ _____	Utilities
\$ _____	Cell phone
\$ _____	Food
\$ _____	School tuition/expenses
\$ _____	Gas
\$ _____	Other
\$ _____	Other
\$ _____	TOTAL

A TESTIMONIAL TO IMPORTANCE OF DISABILITY INSURANCE

Funny how life works

How many times have we heard that saying ... funny how life works? It could be said about Amanda and Zack Fidler's story.

Both were hired in 2011, Amanda as a Payroll Specialist in the Auditor's office and Zack as a Telecommunications Project Manager in PFM. Their meeting was happenstance. Zack was installing the County's new phone system. Amanda was asked to work with PFM to learn more about the new system and oversee the installation within her department. Their first contact with each other was an email from Amanda to Zack inquiring about the phone system. Their marriage took place one year to the day, to the hour, to the minute of that first email. That email hangs framed in their home. Funny how life works.

Fast forward several years, Amanda and Zack have a pretty busy life with two full-time careers and five kids. Maggie Snow, Director of Benefits and Risk Management, sat down with Amanda to discuss why she and Zack are taking advantage of the opportunity to purchase disability this year.

"You never know what is going to happen."

One of Amanda's first statements to Maggie was, "You never know what is going to happen." Recently while driving on the freeway, a large metal object fell off of the vehicle in front of Amanda's car. Fortunately, Amanda escaped injury. "It was very scary. On any given day, these kinds of things can happen. I want disability insurance in case it does."

Amanda is very budget conscious and forward thinking when it comes to her family's finances. She and Zack are doing all the right things ... saving as much sick and vacation time as possible and taking advantage of the savings programs available through the County. But she realizes, "If I were to be disabled, it would be a huge blow to our finances and could derail our plans for the future. Signing up for the disability insurance is a no brainer."

Amanda uses her recent maternity leave as an example. She was very conscious about holding on to her sick and vacation time prior to going on leave so that she could take as much time off as she could to spend with the new baby. But ... funny how life works ... unexpected things happened. "Every time they cancelled school for cold weather, it would just stop my heart because I was going to have to take another day off. Had I had disability insurance, I would have been able to prolong my maternity leave."

Amanda also looks at it from her parents perspective. "We see our parents wanting to spend time with their grandchildren. Zack and I are working hard to plan for retirement, but a disability could mean dipping into our savings. It is not something we want to do, but if we needed to, we would." Without the income protection disability insurance provides, Amanda and Zack's retirement could look very different than what they envision if one of them suffers a disability.

"It is something that is important to us and something that we can sustain in our budget. We are looking forward to signing up to provide a safety net for our family's future."



Amanda and Zack Fidler review documents about MetLife's disability insurance available through the Cooperative.

SHORT AND LONG TERM DISABILITY CALCULATOR

SHORT TERM DISABILITY INSURANCE

Your short term disability **benefit** (the amount you are receive from MetLife) is paid to you **WEEKLY**.
Your short term disability **premium** (the amount deducted from your paycheck) is paid **MONTHLY**.

LONG TERM DISABILITY INSURANCE

Your long term disability **benefit** (the amount you are receive from MetLife) is paid to you **MONTHLY**.
Your long term disability **premium** (the amount deducted from your paycheck) is paid **MONTHLY**.

OPTIONS FOR CALCULATING YOUR BENEFIT AND PREMIUM

1. Manually calculate your benefit and premium using the table below.
2. Record your gross annual salary and age and have your benefit and premium automatically calculated here:
<http://bewell.franklincountyohio.gov/calculators/disability-plan-contribution-worksheet/index.cfm>
3. Go to <https://fccbenefits.com> and click on the Disability tab.

If you enroll in the disability insurance program, your monthly premium is divided into two deductions: half of your monthly premium is deducted from the first pay of the month; the second half of your monthly premium is deducted from the second pay of the month. If there is a third pay of the month, there is no deduction taken from that pay.

SHORT and LONG Term Disability Insurance Benefits and Premium Worksheet

This worksheet approximates your monthly (not per pay) Short and Long Term premiums. Actual contributions will be calculated by MetLife.

SHORT Term	
A. Annual Earnings = (Gross earnings, before taxes)	
B. Weekly Earnings = (A. divided by 52)	
C. Weekly Benefit = (B. x 60% or .60)	
D. Value Per \$10 = (C. divided by 10)	
E. Enter applicable age-banded Rate (See Premium Rates below)	
F. Estimated Monthly Premium = (D. multiplied by E.)	

LONG Term	
A. Annual Earnings = (Gross earnings, before taxes)	
B. Monthly Earnings = (A. divided by 12)	
C. Value Per \$100 = (B. divided by 100)	
D. Enter applicable age-banded Rate (See Premium Rates below)	
E. Estimated Monthly Premium = (C. multiplied by D.)	

Short Term Disability Premium Rates	Rate per \$10
Less than 30	\$0.42
30-39	\$0.41
40-49	\$0.47
50-59	\$0.71
60-64	\$0.93
65+	\$0.93

Long Term Disability Premium Rates	Rate per \$100
Less than 30	\$0.44
30-39	\$0.53
40-49	\$0.79
50-59	\$0.81
60-64	\$0.66
65+	\$0.48

DO YOU SEE YOURSELF IN THESE SCENARIOS?

SCENARIO #1: The planned pregnancy ...

This is Kristen and Michael. They hope to start a family soon.

Kristen works for the County. She wants to take a 12 week maternity leave. She'll have some vacation and sick time built up by the time she needs to go on leave, but

not enough to carry her for the full 12 weeks. Plus, she doesn't want to exhaust her vacation and sick time while on leave.

Kristen purchases MetLife short term disability during 2016 Open Enrollment with an effective date of April 1, 2016. Kristen's premiums are very reasonable - less than \$30 per month - and she will be assured to have a steady stream of income (60% of her **gross** weekly income) while she is on maternity leave.

March 2017, Michael and Kristen welcome a healthy baby boy. Her doctor certifies her maternity leave for 8 weeks. Kristen uses sick time for the first two weeks of her maternity leave, then her disability payments



kick in for the remaining 6 weeks. Because Kristen didn't need to exhaust her sick and vacation time before her disability benefits kicked in, she has plenty of sick and vacation remaining to continue a steady stream of income for the remaining 4 weeks and have time to take time off for pediatrician visits and a vacation in the summer. With the income replacement that her MetLife short term disability provided, she had ample funds to continue to pay for

household expenses (like groceries, car payment, or mortgage ... expenses that do not stop when you are on leave!) and maintain a bank of hours to use for needed time away from work after her return from maternity leave.

SCENARIO #2: The unexpected illness or injury ...

This is Brad. Brad is an avid outdoorsman. While biking one weekend in June 2016, Brad hits a pothole and goes head over handlebars straight to the asphalt, suffering a broken shoulder. It is a serious break and Brad's surgeon advises

Brad that he will be unable to work for at least 4 months.

Brad is a County employee. He purchased short term disability during the County's 2016 Open Enrollment. His coverage went into effect April 1, 2016.

When Brad's accident occurred, he didn't have much sick or vacation time - only about two weeks. He used what sick and vacation time he did have to get him through the first two weeks of his recovery. Then his MetLife short term disability payments kicked in.

His weekly disability payments were almost as much as he was making before his disability because they were based on his gross weekly salary.

Brad had some unexpected difficulty during his recovery and he was off work for 6 months. His MetLife short term disability payments kept him afloat and allowed him to keep his home.



BENEFIT CHANGES EFFECTIVE APRIL 1, 2016

BARIATRIC BENEFIT

Current Benefit

100% coverage after a \$1,700 deductible

The \$1,700 deductible applied to bariatric surgery is being reduced to \$200. All other requirements remain the same. Please refer to your Healthcare Benefits Guide or UnitedHealthcare Summary Plan Description (SPD) for more information about this benefit.

New Benefit

100% coverage after a \$200 deductible

GENDER IDENTITY DISORDER

Current Benefit

Not covered

Gender Identity Disorder (GID) is a condition in which a person has been assigned one gender but identifies as belonging to another gender. Treatment of GID includes a multidisciplinary approach involving medical, pharmacy, as well as behavioral health services. There are specific and stringent qualifications that must be met in order to qualify for services. Please refer to your Healthcare Benefits Guide or UnitedHealthcare Summary Plan Description (SPD) for more information about this benefit.

New Benefit

Covered

MISSING TOOTH EXCLUSION

Current Benefit

Not covered

The Plan will cover dentures, bridges, inlays or crowns to replace teeth that were lost while not covered by the plan. All current plan deductibles, coinsurance and annual maximums apply.

New Benefit

Covered

EMPLOYEE CONTRIBUTION HOLIDAY IN APRIL

As announced in County Administrator Kenneth N. Wilson's front page message, all Cooperative members will receive an employee contribution 'holiday' in the month of April. Your 'holiday' is equal to 1/2 of your April employee contribution.

Employee contributions for the health plan are taken from the first and second pays of the month - half is deducted from your first pay and half deducted from your second pay. Your first pay in April will have \$0 contribution deducted. Your second pay in April will have your normal per pay contribution (or 1/2 of your total monthly contribution) deducted. Your contribution for the remaining months of the 2016 plan year will be a full amount.

This does not impact your disability, supplemental life or Flexible Spending Account (FSA) deductions.



EXAMPLE	
2016 monthly employee contribution amount	\$124 or \$253
Contribution amount taken from first pay in April	\$0
Contribution amount taken from second pay in April	\$62 or \$126.50

PLAN YEAR CHANGE EFFECTIVE JANUARY 1, 2017

The Cooperative's plan year will change to a calendar year plan year effective January 1, 2017. This change will allow the plan year to follow the County's budget cycle as well as help those employees enrolled in the Flexible Spending Account (FSA) program to better estimate annual elections.

CURRENT PLAN YEAR Last 3 months of the 2015 plan year			2016 PLAN YEAR April 1st through December 31st 9 months								
Jan 2016	Feb 2016	Mar 2016	Apr 2016	May 2016	Jun 2016	Jul 2016	Aug 2016	Sep 2016	Oct 2016	Nov 2016	Dec 2016
2017 PLAN YEAR January 1st through December 31st 12 months											
Jan 2017	Feb 2017	Mar 2017	Apr 2017	May 2017	Jun 2017	Jul 2017	Aug 2017	Sep 2017	Oct 2017	Nov 2017	Dec 2017

2016 PLAN YEAR

- Your Open Enrollment is being held from February 8, 2016, through February 26, 2016.
- Open Enrollment changes are effective April 1, 2016.
- The 2016 plan year begins April 1, 2016.
- The 2016 plan year ends December 31, 2016.
- The 2016 plan year lasts for 9 months.

2017 PLAN YEAR

- Your 2017 Open Enrollment will be held in November 2016, with Open Enrollment changes effective January 1, 2017.
- The 2017 plan year begins January 1, 2017.
- The 2017 plan year ends December 31, 2017.
- The 2017 plan year lasts 12 months.

SPECIAL ENROLLMENT NOTICE

If you are declining enrollment for 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 your or your dependents' other coverage). However, you must request enrollment within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage). In addition, if you have a new dependent as a result 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 after the marriage, birth, adoption, or placement for adoption. If you do not request enrollment within 30 days, your request to enroll your dependent will be denied.

SUMMARY OF MEDICAL BENEFITS

	NETWORK	NON-NETWORK
MEDICAL PLAN		
Office Visit Copay (OV) - Preventive Care - Non-Preventive Care - Premium Tier I Specialist - Non-Premium Tier I Specialist	\$0 \$20 \$20 \$40	
Therapies and Chiropractic Copay - Limited to 25 visits per plan year	\$20	Annual Deductible \$400 Individual \$1,000 Family
Urgent Care Copay (UC)	\$25	Coinsurance You pay 20%. Plan pays 80%.
Emergency Room Copay (ER)	\$150	Annual Maximum Out-of-Pocket \$1,200 Individual \$3,000 Family
Inpatient Hospitalization, Outpatient Surgery, Major Diagnostic, Ancillary Services, etc. - Deductible - Coinsurance - Maximum Out-of-Pocket (MOOP) Ambulance services not subject to the deductible effective April 1, 2014.	Annual Deductible \$200 Individual \$500 Family Coinsurance You pay 0%. Plan pays 100%. Annual Maximum Out-of-Pocket \$600 Individual \$1,500 Family	
Do copays apply to the deductible?	No	No
Do copays apply to the MOOP?	Yes	No
Does the deductible apply to the MOOP?	Yes	Yes
Amounts applied to the medical deductible and MOOP will also be applied to the behavioral health deductible and MOOP and vice versa.		

UnitedHealthcare's HEALTH4ME

UnitedHealthcare is making it easier for you to take greater control of your health through a free mobile app called Health4Me™.

Available for the Apple® iPhone®, iPad® and Android®, Health4Me provides you 24/7 access to a registered nurse, enables you to locate a nearby in-network physician, hospital or urgent care, and gives you access to your personal health benefits information.



Health4Me's "Easy Connect" feature lets you select the type of questions you have about your claims and benefits, and request a callback on your mobile device from a UnitedHealthcare customer service representative. You can also download your health plan ID card to your smartphone, and email or fax the ID card directly from the mobile device to your physician's office or hospital. You can view information on the status of deductible and out-of-pocket spending. The Health4Me app makes navigating health care easier for you and your family and puts key information, including health and wellness tools, literally at your fingertips.

HEALTHY PREGNANCY PROGRAM

The Healthy Pregnancy Program provides continuous support during pregnancy through print materials, website resources and one-on-one telephonic interaction with maternity nurses. Receive a \$50 gift card incentive upon enrollment in the program and an additional \$150 gift card upon completion of the program. Gift cards are taxable.



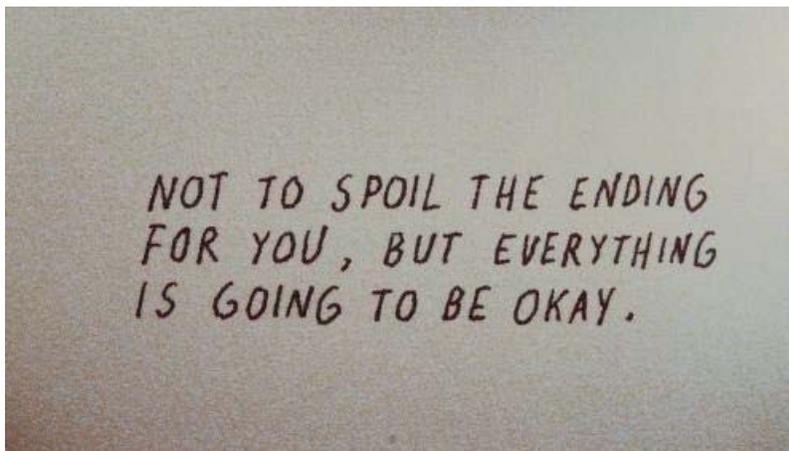
Enroll today.
1-888-246-7389
Monday through Friday
8 a.m. to 8 p.m. CST

SUMMARY OF BEHAVIORAL HEALTH BENEFITS

	NETWORK	NON-NETWORK
BEHAVIORAL HEALTH PLAN		
Outpatient Copay - First 30 visits - 31st visit +	\$0 \$20	Annual Deductible \$400 Individual \$1,000 Family
Inpatient Hospitalization for Mental Health or Substance Abuse treatment	No Deductible No Coinsurance Plan pays 100%. Annual Maximum Out-of-Pocket \$600 Individual \$1,500 Family	Coinsurance You pay 20%. Plan pays 80%. Annual Maximum Out-of-Pocket \$1,200 Individual \$3,000 Family
Do copays apply to the deductible?	N/A	No
Do copays apply to the MOOP?	Yes	No
Does the deductible apply to the MOOP?	N/A	Yes
Amounts applied to the behavioral health deductible and MOOP will also be applied to the medical deductible and MOOP and vice versa.		

EMPLOYEE ASSISTANCE PROGRAM (EAP)		
- 8 visits per problem per plan year	No copay	N/A

EAP benefits are available to any member of your household. For example, if you have a parent living with you, your parent would be eligible for EAP benefits even though your parent is not covered under the health plan.



Employee Assistance Program (EAP) and behavioral health benefits are administered by the same company - Optum United Behavioral Health (UBH). Both programs provide counseling resources when faced with life challenges. - but they are two very distinct programs.

Behavioral Health provides coverage for inpatient and outpatient mental health or substance abuse treatment, beyond what is covered under the EAP.

The EAP offers benefits not available through behavioral health, including:

- Legal consultation from a licensed attorney
- Mediation services
- Financial counseling from a financial professional

www.liveandworkwell.com, the Optum UBH website provides information on both your behavioral health and EAP benefits. It also offers an enormous resource library of articles about many topics including bullying to depression to preparing for college as well as downloadable do-it-yourself will kits and financial retirement calculators.

To access services, log onto the www.liveandworkwell.com website or call Optum United Behavioral Health at 1-800-354-3950.

SUMMARY OF PRESCRIPTION DRUG BENEFITS

	NETWORK RETAIL	MAIL ORDER
PRESCRIPTION DRUG PLAN		
Non-Specialty Medications		
Generic (G) Copay	\$5	\$12.50
Preferred Brand (PB) Copay	\$25	\$62.50
Non-Preferred Brand (NPB) Copay	\$50	\$125
Maximum Out-of-Pocket Cost	\$4,000 Individual \$10,000 Family	
Proton Pump Inhibitors		
Generics and over the counter Copay	\$5	\$12.50
Preferred Brand (PB) Copay	\$50	\$125
Non-Preferred Brand (NPB) Copay	\$75	\$187.50
Specialty Medications		
Generic (G) Copay	\$5	\$12.50
Preferred Brand (PB) Copay	\$25	\$62.50
Non-Preferred Brand (NPB) Copay	10% up to \$150 per prescription	10% up to \$300 per prescription
Injectible Insulin		
Diabetic supplies - Lancets, syringes, test strips, etc.		
	Covered 100% Pharmacy plan: Covered 100%	Covered 100% Pharmacy plan: Covered 100%
Do copays apply to the deductible?	N/A	N/A
Do copays apply to the MOOP?	Yes	Yes
Does the deductible apply to the MOOP?	N/A	N/A

FORMULARY CHANGES

The majority of changes to the OptumRx/CatamaranRx formulary occur on January 1st each year. However, changes can be made during the year due to shifts in the pharmaceutical marketplace and the availability of new medications. Prior to filling a medication, it is recommended that you confirm the formulary status of the medication.

PRIOR AUTHORIZATION

Prior Authorization is required from OptumRx/CatamaranRx before certain drugs will be dispensed. Prior Authorizations are not intended to create a barrier to treatment, but to make sure that the right drug is being dispensed to the right person for the right medical condition. In most cases, your doctor must provide clinical information before the authorization is approved.



OPTUMRx

OptumRx purchased CatamaranRx. In some cases, your pharmacy benefit may still be referenced through CatamaranRx and in others OptumRx. New identification cards will illustrate the OptumRx logo.

SUMMARY OF VISION and DENTAL BENEFITS

	NETWORK	NON-NETWORK
VISION		
Exam (every 12 months)	100% after \$10	Reimbursed up to \$40
Lenses (every 12 months)	100% after \$20	Reimbursed up to \$50-\$70
Polycarbonate	Covered 100%	N/A
Anti-Reflective Coating (ARC)	\$20 allowance	N/A
Frames (every 24 months)	Allowance \$140 (retail) \$53 (wholesale)	Reimbursed up to \$30
Frames for children < age 12 (every 12 months)	Allowance \$140 (retail) \$53 (wholesale)	Reimbursed up to \$30
Contact Lenses (every 12 months in place of glasses)	\$140 allowance Fitting and evaluation capped at \$60	Reimbursed up to \$80

PLAN YEAR RESETS EFFECTIVE APRIL 1st

When a new plan year begins, your benefits 'reset'.

Any portion of your annual medical, behavioral health or dental deductible or annual maximum-out-of-pocket amount met during the prior plan year does not apply to the new plan year. Your annual deductibles and maximum-out-of-pocket amounts are 'reset' to \$0.

The number of visit for therapies (physical, speech, occupational) and chiropractic care 'reset' to 25.

Your annual maximum dental benefit resets to \$1,500 in-network and \$1,000 out-of-network.

	PPO		DMO COVERAGE ONLY FOR NETWORK PROVIDERS
	NETWORK	NON-NETWORK	
DENTAL PPO PLAN			DMO PLAN
Annual Deductible	None	\$25 per person	None
Coinsurance			
The plan pays:			
- Diagnostic	100%	90%	100%
- Preventive	100%	90%	Fixed copay
- Basic	80%	70%	Fixed copay
- Major Restorative	80%	60%	Fixed copay
Maximum Annual Benefit	\$1,500	\$1,000	Based on fixed copays
Orthodontia	Children under 19 only	Children Under 19 only	Children and Adult
Coinsurance			
The plan pays:	75%	75%	Fixed copays
Maximum Lifetime Benefit	\$1,500	\$1,400	Based on fixed copays

**I'M NEVER SURE
WHAT TO DO
WITH MY EYES
WHEN I'M AT THE
DENTIST. DO I
CLOSE THEM?
DO I STARE AT HIS
FACE? DO I LOOK
AT THE CEILING?
I MEAN WHAT'S
THE PROPER
ETIQUETTE HERE?**

Choosing Wisely®

Choosing Wisely® wants you to talk to your doctor ... to ask questions. *Do I really need that test? Can I hold off on that antibiotic?* By arming you with the proper information and encouraging you to ask the right questions, Choosing Wisely® wants to help you choose care that is:

- Supported by evidence, i.e. that really works!
- Not duplicative of other tests or procedures already received
- Free from harm, i.e. the risks don't outweigh the benefits!
- Truly necessary

Choosing Wisely® partnered with national medical organizations representing many types of physicians. These organizations were asked to identify tests or procedures commonly used that really should be discussed before being ordered. For example, the Academy of Family Physicians identified and recommended the following:

Don't do imaging (x-rays) for lower back pain within the first six weeks, unless red flags are present. *Imaging of the lower spine before six weeks does not improve outcomes, but does increase costs.* Low back pain is the fifth most common reason for all physician visits.

Don't routinely prescribe antibiotics for acute mild-to-moderate sinusitis unless symptoms last for seven or more days, or symptoms worsen after improvement. Most sinusitis is due to a viral infection that will resolve on its own. *Despite consistent recommendations to the contrary, antibiotics are prescribed in more than 80 percent of outpatient visits for acute sinusitis.* Sinusitis accounts for 16 million office visits and \$5.8 billion in annual health care costs.

Don't order annual electrocardiograms (EKG) or any other cardiac screening for low-risk patients without symptoms. There is little evidence that screening for coronary artery disease (artery blockage) in low risk patients who show no symptoms, improves health outcomes. False-positive tests are likely to lead to harm through unnecessary invasive procedures, over-treatment and misdiagnosis. *Potential harms of this routine annual screening exceed the potential benefit.*

Check out the Choosing Wisely® website at www.choosingwisely.org for more information, including a whole host of recommendations based upon your condition. For example:

- Colonoscopy: When you need it
- Hard decisions about cancer
- Lab tests before surgery: When you need them
- Physical Therapy: Five treatments you probably don't need
- Treating migraine headaches: Some drugs should rarely be used



An initiative of the ABIM Foundation

Choosing Wisely® Partners include over 70 medical and consumer-focused organizations working to help providers, patients and health care stakeholders **think and talk** about overuse of health care resources in the United States. The list includes:

ABIM Foundation
 American Academy of Allergy, Asthma & Immunology
 Academy of Family Physicians
 American Academy of Neurology
 American Academy of Pediatrics
 American Academy of Orthopaedic Surgeons
 American College of Cardiology
 American College of OB/GYN
 American College of Preventive Medicine
 American College of Rheumatology
 American Psychiatric Association
 American Society of Clinical Oncology
 Commission on Cancer
 Infectious Diseases Society of America
 Robert Wood Johnson Foundation
 Society of Critical Care Medicine
 Society of Vascular Medicine

Choosing Wisely® is working with about 20 organizations to distribute information and educate patients on making wise decisions, including the following:

AARP
 The Leapfrog Group
 National Partnership for Women & Families
 Union Plus
 Wikipedia

Go to www.choosingwisely.org to find out more about the **Choosing Wisely®** initiative.

BASIC LIFE and AD&D INSURANCE

If you are a benefits eligible employee, Basic Life and Accidental Death & Dismemberment (AD&D) insurance is provided to you at no cost.

Basic Life pays a benefit upon death due to illness or injury. AD&D doubles the death benefit if death is due to an accident or pays a partial benefit for injuries sustained as a result of an accident. The AD&D payment schedule for death or injury is illustrated in the Certificate of Insurance.

The Basic Life/AD&D coverage amount provided to you is illustrated at <https://fccbenefits.com>.

ADDITIONAL LIFE INSURANCE BENEFITS

Line of Duty: Pays a benefit when a public safety officer suffers a loss for which AD&D benefits are payable and it is the result of a line of duty accident. Covers sheriff, deputies, correction and judicial officers.

FrontierMEDEX Travel Assist: Offers assistance when traveling with pre-trip planning, locating medical care abroad, interpretation services, passport replacement, legal assistance, etc. In the US, Canada, Puerto Rico, US Virgin Islands and Bermuda, call 1-800-527-0218. In other locations worldwide, call 1-410-453-6330 collect. You can also email FrontierMedex at operations@frontiermedex.com.

Occupational Assault: Pays a benefit when, while actively at work, a loss results from an act of physical violence punishable by law.

Seat Belt: Pays a benefit if, while properly wearing a seat belt, death results from a car accident.

Accelerated Death: Pays the member a percent of the life insurance benefit, while living, when diagnosed with a terminal illness.

Portability/Conversion: Upon termination of employment or loss of eligibility, allows the member to 'take the coverage with them'. Restrictions apply and a request must be made within 31 days of coverage termination. Contact Standard at 1-800-378-4668, ext. 6785 for more information.

BASIC LIFE INSURANCE COVERAGE AMOUNTS

Fairfield County

\$125,000	Class 1: BDD Superintendent
1x annual salary	Class 2: BDD Management
\$21,000	Class 3: BDD Non-Management
\$50,000	Class 6: All Other Employees

Franklin County

\$50,000	Class 5: All Other Employees
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Pickaway County

\$30,000	Class 7: Human Services Dept
\$25,000	Class 8: All Other Employees

City of Grandview

\$75,000	Class 9: City of Grandview
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SUPPLEMENTAL LIFE INSURANCE

If you need more life insurance than is provided by your Basic Life/AD&D benefit, you can purchase Supplemental Life coverage.

- Supplemental Life can be requested up to the following maximum amounts:
 - Employee: In \$10,000 increments **up to \$300,000**
 - Spouse/Partner: In \$10,000 increments **up to \$150,000**
 - Dependent Children: In \$5,000 increments **up to \$10,000**
- The Guaranteed Issue amounts are as follows:
 - Employee: Up to \$100,000
 - Spouse/Partner: Up to \$50,000
 - Dependent Children: Up to \$10,000
- 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 spouse/partner on April 1st.
- All life insurance enrollments are made at <https://fccbenefits.com>.
- Beneficiaries named for Supplemental Life can be different than the beneficiaries named for Basic Life/AD&D.
- If you leave County employment, you can 'take the coverage with you' by porting or converting.
- Evidence of Insurability (EOI) is an application process in which you provide information on the condition of your health in order to be considered for insurance coverage. EOI **does not** need to be submitted for Basic Life/AD&D. EOI **does** need to be submitted for certain Supplemental Life requests. All EOI requests must be submitted to the life insurance carrier by April 30, 2016.

\$10,000 BUMP WITH NO UNDERWRITING

If you are currently enrolled in the Supplemental Life program, you may increase your supplemental life coverage, as well as the coverage of your spouse/partner, by \$10,000 without supplying any medical history. Increase your coverage at <https://fccbenefits.com>.

If you are not currently enrolled in the Supplemental Life program, all Supplemental Life coverage requested for yourself, your spouse or your children will require approval during Open Enrollment.

SUPPLEMENTAL LIFE RATES

Supplemental Life provides additional life insurance for employees and coverage for spouses/partners and dependent children. Proceeds are paid upon death due to illness or injury and do not double or pay a partial benefit due to accidental death or injury.

Supplemental Life Rates Effective April 1, 2016

Rates for Employee and Spouse/Domestic Partner

**\$10,000 increments up to \$300,000
- GI Amount \$100,000**

Age	Monthly Rate per \$10,000 of Coverage
<25	\$0.50
25-29	\$0.60
30-34	\$0.67
35-39	\$0.72
40-44	\$1.00
45-49	\$1.50
50-54	\$2.30
55-59	\$4.30
60-64	\$6.60
65-69	\$10.34
70-74	\$20.60
75+	\$20.60

Rates are based on age as of April 1, 2016.

Rates for Child(ren)

**\$5,000 increments up to \$10,000 -
GI Amount \$10,000**

Amount	Monthly Cost
\$5,000	\$0.65
\$10,000	\$1.30

Child rates cover all children in the family. For example, if a \$10,000 benefit is elected the cost is \$1.30 regardless of the number of dependent children.

EMPLOYEE CONTRIBUTIONS EFFECTIVE APRIL 1, 2016

Effective April 1, 2016, employee contributions for the agencies illustrated here will be as follows:

Coverage Level	Monthly Contribution Amount
Employee only	\$124
Employee with child(ren)	\$124
Employee with spouse or domestic partner	\$253
Employee with family	\$253

Your 2016 monthly contribution amount will be illustrated in the enrollment system at <https://fccbenefits.com>.

Payroll deductions for health benefits are deducted pre-tax. If a domestic partner is enrolled, the portion of the employee contribution charged for the domestic partner is deducted post-tax, i.e. \$124 is deducted pre-tax; \$129 is deducted post-tax.

* Domestic partner coverage is not applicable to Pickaway County employees.

AGENCY NOT LISTED

If your agency is not listed here, please contact your agency or log onto <https://fccbenefits.com>.

At <https://fccbenefits.com>, look for the green apple. Click the green **START HERE** button. The system will walk you screen by screen through your benefit elections and show your options and cost.



- **ADAMH** Board of Franklin County
- Franklin County Department of **Animal Control** +
- Franklin County **Auditor**
- Franklin County **Benefits and Risk Management** +
- Franklin County **Board of Commissioners** +
- Franklin County **Board of Elections**
- Central Ohio Community Improvement Corporation/**COCIC**
- Franklin County **Child Support** Enforcement Agency +
- Franklin County **Clerk of Courts** +
- Columbus-Franklin County **Finance Authority**
- Franklin County Court of **Common Pleas - General** Division
- Franklin County Court of **Common Pleas - Domestic/Juvenile** Division
- Franklin County **Community Based Correctional Facility**
- Franklin County **Coroner** +
- Franklin County **Data Center**
- Franklin County **Economic Development & Planning** Department +
- Franklin County **Emergency Management** and Homeland Security
- Franklin County **Engineer** +
- Franklin County **Fleet Management** Department +
- Franklin County Office of **Homeland Security & Justice** Programs
- Franklin County **Human Resources**
- Franklin County **Job & Family Services** +
- Franklin County **Law Library**
- Columbus and Franklin County **Metropolitan Park District**
- Franklin County **Office on Aging** +
- Franklin County **Probate** Court
- Franklin County **Prosecutor**
- Franklin County **Public Defender**
- Franklin County **Public Health**
- Franklin County Department of **Public Facilities Management** +
- Franklin County **Purchasing** Department +
- Franklin County **Recorder**
- Franklin County **Sanitary Engineer**
- Franklin County **Sheriff** ++
- Franklin County **Treasurer**
- Franklin County **Veterans Service** Commission +

+ Bargaining and Non-bargaining

++ All Bargaining included except Unit 2 and FOP Lodge 9

IRS FORM 1095/1095

Health care reform, also known as the Affordable Care Act (ACA), went into effect in March 2010. One of the goals of the ACA is to make health insurance available to everyone, regardless of medical history or ability to pay. The ACA also changed the information each individual must provide to the Internal Revenue Service (IRS) when filing income taxes.

One provision of the ACA, called the “individual mandate”, requires each American to have health insurance (with a few exceptions). Individuals who don’t have coverage must pay a tax penalty to the IRS called the “Individual Shared Responsibility Payment”.

Penalties take effect with the 2015 tax year, and are payable with 2015 income taxes (filed in early 2016).

HOW DOES THE IRS KNOW I’VE HAD COVERAGE?

When filing 2015 taxes, you will need to tell the IRS whether you had coverage during the year. There is a new line item on Form 1040 under “Other Taxes” (Line 61) to document if you had health coverage.

WHAT DOES THE 1095 FORM DO FOR ME?

Employers who sponsor self-funded health plans generally must provide a Form 1095-C to employee **by March 31, 2016.**

Form 1095-C provides the following:

- It illustrates that your employer offered you the opportunity to enroll in ACA-compliant coverage, i.e. minimum essential coverage*.
- It also shows if you and your dependents enrolled in the coverage offered by your employer in 2015.

If you enrolled in coverage (or had ACA-compliant coverage from another source), you will not be subject to a tax penalty.

HOW WILL I RECEIVE MY FORM 1095-C?

You will receive your Form 1095-C by mail **no later than March 31, 2016.**

WHAT SHOULD I DO WITH MY 1095-C FORM?

Use it as a reference when completing 2015 taxes. Do not send Form 1095-C to the IRS with your tax return. Your employer will send a copy of Form 1095-C to the IRS for you. Do share it with a tax preparer or advisor, if using one and keep a copy with filed tax returns for future reference.

WHAT IF I CHANGED EMPLOYERS IN 2015?

If you had more than one employer in 2015, you may receive more than one 1095 tax form.

WHO CAN I CONTACT WITH QUESTIONS?

Contact your tax advisor for any questions regarding the tax penalty and how to complete Form 1040. If you have questions about coverage information reported on the 1095 form, contact the Franklin County Benefits Office.

* Your health care coverage through the Franklin County Cooperative qualifies as ACA-compliant or minimum essential coverage. If an individual was covered from January 1, 2015, through December 31, 2015, by the Cooperative’s health plan, that individual satisfied the “individual mandate” requirement.

Form 1095-C Department of the Treasury Internal Revenue Service		Employer-Provided Health Insurance Offer and Coverage ► Information about Form 1095-C and its separate instructions is at www.irs.gov/1095c .				<input type="checkbox"/> VOID <input type="checkbox"/> CORRECTED
Part I Employee			Applicable Large Employer Member (Employer)			
1 Name of employee	2 Social security number (SSN)	7 Name of employer	8 E			
3 Street address (including apartment no.)		9 Street address (including room or suite no.)	10 C			
4 City or town	5 State or province	6 Country and ZIP or foreign postal code	11 City or town	12 State or province	13 C	

Franklin County Courthouse HOJ Room #1 meetings are open to all employees. Spouse/partners are welcome to attend. A meeting should last no longer than 45 minutes. If you are unsure of the location of your meeting, please contact your agency.

MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY
Feb 8th	Feb 9th	Feb 10th	Feb 11th	Feb 12th
OPEN ENROLLMENT BEGINS Fleet Management/ Sheriff Substation 8am	Franklin County Children Services E Main St, Room 136 9am MORPC 9am Franklin County Coroner 2pm	Franklin County Sheriff Jackson Pike 6:30am & 2:30pm PFM Auditorium 9am SWACO 10:30am Franklin County Children Services Mound St, FC Room 2pm	Franklin County Courthouse HOJ Room #1 10am & 2pm Franklin County JFS West 9am Franklin County Engineer 9am EMA 12pm Franklin County Board of Elections 2pm	Memorial Hall 9am Franklin County Sheriff 410 S High St Annex 9am & 2pm Pickaway County Commissioners 10am Pickaway County Engineers 11:30am Pickaway County Sheriff 2pm
Feb 15th	Feb 16th	Feb 17th	Feb 18th	Feb 19th
HOLIDAY	Franklin County JFS East 9am Franklin County Children Services Frank Rd, Room 28 9am SWACO 2pm	ADAMH 9am Franklin County JFS Northland 9am & 10:30am Franklin County Children Services Mound St, FC Room 2pm	Franklin County Courthouse HOJ Room #1 10am & 2pm Auditor/Data Center 10am, 2pm & 3:30pm Franklin County Common Pleas Combined with HOJ Room #1 2pm EDP 3pm	Purchasing 8:30am Clerk of Courts Great Southern 8:30am Franklin County Treasurer 10am & 2pm Memorial Hall 2pm
Feb 22nd	Feb 23rd	Feb 24th	Feb 25th	Feb 26th
Franklin County Child Support Fulton St 9am & 1pm Prairie Township 10am FCCFA 1pm	Prairie Township 10am Metro Parks Blacklick Woods 10am Animal Control 2pm	Animal Control 10am CBCF 1pm Metro Parks Highbanks 1:30pm	Franklin County Courthouse HOJ Room #1 10am & 2pm Franklin County Domestic Relations HOJ Room #3 12:30pm	OPEN ENROLLMENT ENDS

INFO TO KNOW

W-2 HEALTH CARE COSTS

The Patient Protection and Affordable Care Act (PPACA) requires your employer to report the cost of your health benefits on your W-2. This reporting is for information purposes only. The reported cost of your health care benefits represents both your contribution as well as your employer's contribution. Look for Box 12 on your W-2. The amount labeled "Code DD" is your reported health care cost.

SUMMARY OF BENEFITS AND COVERAGE (SBC)

Your Summary of Benefits and Coverage (SBC) and Uniform Glossary provides clear, consistent and comparable information about your health benefits in a simple question-and-answer format. The Uniform Glossary provides definitions of the terms used in the SBC.

Your SBC is posted on the enrollment system at <https://fccbenefits.com> and on the Benefits Office webpage at <http://bewell.franklincountyohio.gov>. Paper copies are available from the Franklin County Benefits Office.

For questions about your W-2 or your SBC, contact the Franklin County Benefits Office by phone at 614-525-5750, toll-free at 1-800-397-5884 or by email at Benefits@franklincountyohio.gov.

WOMEN'S HEALTH AND CANCER RIGHTS ACT (WHCRA)

The Women's Health and Cancer Rights Act 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 her physician.

If you would like more information about WHCRA required coverage, you can contact the Franklin County Benefits Office at 614-525-5750, toll-free at 1-800-397-5884 or by email at Benefits@franklincountyohio.gov.

COUNTY CONTACT INFORMATION

Franklin County Benefits and Risk Management Department

Franklin County Courthouse
373 S. High Street, 25th Floor
Columbus, OH 43215
Website: <http://bewell.franklincountyohio.gov>
Local: 614-525-5750
Toll-free: 1-800-397-5884
Email: Benefits@franklincountyohio.gov
Hours: M-F, 8am - 5pm

Thrive On

Thrive On: 614-525-5750 or 614-525-3948
Thrive On Email: ThriveOn@franklincountyohio.gov
Website: <http://bewell.franklincountyohio.gov>

Fairfield County Benefits Office

239 West Main Street
Lancaster, OH 43130
Local: 740-652-7893
Hours: M-F, 8am - 4:30pm

Pickaway County

Pickaway County Commissioner's Office
April Dengler
Local: 740-420-5450
Fax: 740-474-8988
Email: adengler@pickaway.org
Hours: M-F, 8am - 5pm

CHECKLIST FOR DEPENDENT ELIGIBILITY

At Open Enrollment, you are asked to review the eligibility requirements of the plan to ensure your dependents continue to meet the definition of an *eligible dependent*. For each child you currently have covered or intend to request coverage for during this Open Enrollment, answer the following questions to determine eligibility:

TO CONFIRM ELIGIBILITY FOR A CHILD: Place a ✓ in each box that applies.

STEP 1: My child is:

- A natural, step or adopted (includes placed for adoption) child of mine, my spouse or my domestic partner
- A child for whom legal guardianship has been awarded to me, my spouse or my domestic partner
- A child for whom health care coverage is required through a “Qualified Medical Child Support Order”.
- A grandchild, i.e. a child of an eligible dependent child and the parent of that grandchild, i.e. your dependent child is covered under the plan

If you did not check a box in STEP 1, your child is **NOT** eligible. If you checked a box in STEP 1, proceed to STEP 2.

STEP 2: My child is:

- Less than 26 years of age
- A disabled dependent, defined as a child of any age who is not able to be self-supporting because of a mental or physical disability that began while the child was an eligible dependent.

If you checked a box in STEP 2, your child is eligible. If you did **NOT** check a box in STEP 2, your child is **NOT** eligible. If you are currently covering an ineligible dependent, please remove your dependent from coverage during Open Enrollment. Covering an ineligible dependent (spouse and/or child) is considered fraud and is punishable up to and including termination of employment.

YOUNG ADULT DEPENDENT COVERAGE

Effective April 1, 2016, the Cooperative will no longer offer Young Adult Dependent coverage to non-disabled dependents over the age of 26.

- The Plan will continue to offer coverage to disabled dependents over age 26. A disabled dependent is defined as a child who is unable to be self-supporting because of a mental or physical disability that began while the child was an eligible dependent.
- The Plan will grandfather any dependent currently in health or life Young Adult Dependent coverage. Coverage will continue until the earlier of: a) the dependent ceases to meet the Young Adult Dependent eligibility criteria; or b) the end of the month in which the dependent turns age 28. You will be required to recertify the Young Adult Dependent status of your dependent during this Open Enrollment. Effective April 1, 2016, the monthly premium for YAD coverage is \$401.