HEALTHCARE BENEFITS GUIDE

Effective January 1, 2022

Franklin County Benefits & Wellness
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Columbus, OH 43215
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Franklin County Cooperative
Health Improvement Program

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FRANKLIN COUNTY COOPERATIVE HEALTH IMPROVEMENT PROGRAM OVERVIEW

The Franklin County Board of Commissioners offers exceptional health benefit plans and programs through the Franklin County Cooperative Health Improvement Program.

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 Cooperative covers the following children 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.

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	EMPLOYEE PAID	EMPLOYER AND EMPLOYEE SHARED COST
• **$50,000 of Basic Life Insurance*** • **$50,000 Accidental Death & Dismemberment (AD&D) Life Insurance*** • **Employee Assistance Program (EAP)** 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. ***Some bargaining units and/or agencies may vary in coverage.**	• **Additional (Supplemental) Life Insurance:** You have the option of electing additional amounts of life insurance for yourself as well as coverage for your spouse or domestic partner and your children. You pay 100% of the post-tax premium. Rates are provided in this guide. • **Short- and Long-Term Disability:** 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):** You have the option of contributing to an employer sponsored Flexible Spending Account (FSA). Both Healthcare FSA and Dependent Care FSA options are available. The advantage of using an FSA is that you reduce your taxable income and use pre-tax dollars to pay for qualified out-of-pocket health and dependent care expenses.	**Benefits package including:** • Medical • Behavioral Health • Prescription Drug • Dental • Vision **You have the option of enrolling in a benefits package which includes the coverages listed above. Benefits are offered as a 'package', i.e., you cannot enroll in medical only or dental only.** Please contact your agency HR/payroll representative to identify your monthly contribution.

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

Even if you decline enrollment in the benefits package, the Employer Paid Basic Life, AD&D Insurance and EAP benefits are provided for you. You are also able to elect Employer Paid Additional/Supplemental Life Insurance, elect Short- and/or Long-Term Disability Insurance and enroll in the Flexible Spending Account program.

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.
- **Fair Market Value:** The fair market value (FMV) of the domestic partner benefit is the value of the benefit or the cost of providing the benefit. This value is taxed as income.

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. Therefore, you are encouraged to research your options thoroughly and to seek advice from a tax advisor.

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 30th day of employment. If you miss this initial enrollment opportunity you must wait until Open Enrollment to enroll.

Access the Enrollment System

First-time login instructions on how to access the self-service enrollment system **fccbenefits.com:**

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 1, 1975, your username would be FCCJOHSMI011975.	Your initial password is your first letter of your first name + your 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 CAPITALIZED letters.
You will be prompted to change your password upon first login.

The enrollment system is accessible from any computer with internet access including home, work, public library, etc. If you do not have a computer 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 these if they change in the future.

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 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, your request to enroll your dependent will be denied. See Your Life Events section.

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, coverage will not be approved and the next opportunity to enroll your dependent is the following Open Enrollment.

Before submitting, 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:

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**
Upload into the online enrollment system:	**Fccbenefits.com**

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.**

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.

Federal restrictions prohibit changing your benefit elections outside of Open Enrollment unless a Life Event occurs.

Your Life Events

Life Events are life changes that occur outside of Open Enrollment that can alter 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, and your disability insurance coverage, and in some circumstances, your FSA. Adding a spouse or domestic partner can also impact the incentives with your wellness programs.

You have 30 days from the date of a Life Event to make changes to your benefits. Eligibility documents are required whenever a dependent is added to or removed from coverage. 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.

Legal separation, divorce and ending a domestic partnership: Dissolution, divorce or termination of a domestic partner is a difficult and life-altering process and can be emotionally and financially challenging.

The **Employee Assistance Program (EAP)** provides services which may help.

- Individual or Family counseling
- Relationship counseling
- Financial consultation
- Legal consultation

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 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 AND 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 designated Life Event 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.

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 to remove child from plan, stating reason for loss of eligibility
Death of Employee	Employee coverage ends the date of death. Dependent coverage continues through the end of same month.	Proof of death is required in the event of dependent death. This can be satisfied with death certificate or copy of the obituary. If a life insurance claim is filed, a life insurance claim form and an original (not a copy) of the death certificate are required.
Death of Dependent	Dependent coverage ends the date of death	

Life Events must be submitted online at **fccbenefits.com**

OPEN ENROLLMENT AND 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.

Your Transfer to a New Agency

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

Your Employee Information in **fccbenefits.com**

If corrections are needed to your:

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

Contact your HR/payroll officer. You cannot make these changes yourself.

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.

Benefit	Carrier	Telephone Number	Website
Benefits	Franklin County Benefits & Wellness Office	614.525.5750 1.800.397.5884	**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**
Employee Assistance Program (EAP)	Optum	1.800.354.3950	**liveandworkwell.com** Access Code: EAP
Wellness	OhioHealth	1-888-255-0162	**fccthriveon.com**
Life Insurance	The Standard	800.378.4668 800.628.8600	N/A
Short- and/or Long-Term Disability	MetLife	1.866.729.9201	**MetLife.com/MyBenefits**
FSA	WEX	1.866.451.3399	**fccbenefits.com** **EMAIL: customerservice@wexhealth.com** Fax: 866.451.3245
Medical	United HealthCare	1.877.440.5983	**myuhc.com**
Behavioral Health	Optum	1.800.354.3950	**liveandworkwell.com** Access Code: EAP
Prescription Drug	OptumRx	1.855.312.2307	**OptumRx.com**
Dental	Aetna	1.877.238.6200	**aetna.com**
Vision	Vision Service Plan	1.800.877.7195	**vsp.com**
COBRA	Benefit Express, a WEX company	1.877.837.5017	**mypremiumbill.com** **HELP EMAIL:** **help@mybenefitexpress.com**

YOUR EMPLOYEE ASSISTANCE PROGRAM (EAP)

Your **Employee Assistance Program (EAP)** offers confidential support for everyday challenges and is available 24 hours a day 7 days a week. Services are available to any member of your household.

You are not required to be enrolled in the benefit package to receive EAP services.

Your EAP benefit allows up to **8** sessions per presenting problem per year for assessment, short-term counseling and/or referral services. This benefit is provided at no charge to you.

Assistance is available for many life challenges, opportunities, and disappointments, including:

- Stress, anxiety, depression
- Workplace conflicts
- Relationship troubles
- Parenting and family problems
- Coping with current event

Accessing EAP services

1.800.354.3950

Services MUST BE obtained from a network provider.

To locate an EAP 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.

Before visiting your clinician, obtain a certification for services at the intake number above or online at **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.

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.

ThriveOn
Your Health and Wellness Program

Intellectual/Emotional: Subject matter focusing on one's mental health and the mind-body link. What goes on in our heads can affect how our bodies operate.

ThriveOn
Your Health and Wellness Program

Physical: The lifestyle choices we make regarding what we eat and what keeps us active have immediate and long-ranging effects on our personal wellness.

ThriveOn
Your Health and Wellness Program

Social/Community: Links to the central Ohio community and the non-profit organizations that can provide help as well as volunteer opportunities for those who want to give back. Helping our community to flourish helps ourselves as well.

ThriveOn
Your Health and Wellness Program

Material: The "stuff" of life that can wear you down. Bringing subject matter experts on legal issues, financial planning, and professional development to help you achieve the life you want.

Some programs offered through the ThriveOn Program are:

- Health Screening & Assessment
- Flu Shots
- Wellness Champions
- Incentive Programs
- Health Coaching
- Wellness Challenges
- Tobacco Cessation Resources
- Nutrition Support
- Gym Membership Reimbursement
- Cooking Demonstration
- Weight Watchers
- Onsite EAP counselor
- Onsite Health Engagement Nurse

Login to **fccthriveon.com** and sign in or create an account today.

YOUR LIFE INSURANCE

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

You may purchase additional life insurance for yourself as well as coverage for your spouse or domestic partner and children. This coverage provides a benefit if death results due to accident or illness.

You pay 100% of the cost of this coverage. Premium is deducted from your paycheck on a post-tax basis. Additional (Supplemental) Life is group term life.

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**

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.

YOUR LIFE INSURANCE

Guaranteed 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.

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

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 is group term insurance at a slightly higher premium rate with some restrictions.
- 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

Additional/Supplemental Life Monthly Rates

Age	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
	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.

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 work day preceding such time off.

The disability insurance program offers the following coverage:

Short-Term Disability*

Income replacement provides you 60% of your gross weekly pre-disability 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 waiting period of 14 days.

Long-Term Disability*

Income replacement provides you with 60% of your gross monthly pre- disability income during an extended illness or injury. After an initial elimination period of 180 days (or until your Short-Term Disability Insurance benefit ends) 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. 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

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 and 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.

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, artificial insemination, 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

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			Long-Term Disability Insurance		
A	Annual Earnings=		A	Annual Earnings=	
B	Weekly Earnings= *(A ÷ by 52)*		B	Weekly Earnings= *(A ÷ by 12)*	
C	Weekly Benefits= *(B x 60%)*		C	Weekly Benefits *(B ÷ by 100)*	
D	Value Per $10= *(C ÷ by 10)*		D	Enter applicable age-banded rate=	
E	Enter applicable age-banded rate=		E	**Estimated Monthly Contribution=** *(C x by the applicable age-banded rate D)*	
F	**Estimated Monthly Contribution=** *(C ÷ by 10)*				

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 FLEXIBLE SPENDING ACCOUNT (FSA)

What's an FSA?

A Flexible Spending Account (FSA) is an employer-sponsored benefit program that allows you to set aside pre-tax dollars from your paycheck to pay for eligible health or dependent care expenses. 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. **This is a 100% voluntary program.**

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	Dependent Care FSA
The dollars you set aside in your health care FSA (HCFSA) account can be used to pay for eligible health care expenses for you, your spouse/domestic partner, and your dependent children. The expenses do not need to be associated with your Cooperative health plan. Dollars set aside into a health care FSA (HCFSA) are available on the 1st day of the plan year.	The dollars you set aside in your Dependent Care FSA (DCFSA) can be used to pay for eligible dependent care expenses like daycare or preschool. Dependent Care FSA (DCFSA) dollars are only available as they are deducted from your paycheck and deposited into your DCFSA account.

Use it or Lose it

FSAs have a 'Use it or Lose it' rule that requires you to incur expenses during the calendar year – January through December and that the funds in those accounts be used no later than the run- out period of March 31st of the following plan year.

Unspent Healthcare FSA Dollars	Unspent Dependent Care FSA Dollars
Up to $550: may be rolled over and used for new expenses in the next calendar year. **Greater than $550:** will be forfeited	**Won't be returned to you** Funds **do not roll over** to the next plan year

Fund Availability

One of the features of your health and dependent care FSA is the FSA Benefits Card/VISA, which gives you easy access to your health and/or dependent care FSA dollars. Swipe your benefits card (just like a regular bank card) and funds are automatically taken from your applicable FSA account and paid to the provider. Paper claim forms can be submitted along with receipts for any claim. If you have elected to be reimbursed by Direct Deposit, your FSA funds are deposited directly into your bank account. Otherwise, a check is mailed to you via US Mail.

YOUR MEDICAL

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.

CHOICE PLUS PPO

In-Network			Out-of-Network
SERVICES SUBJECT TO A COPAY Includes physician office visits, urgent care, emergency care, therapies, and chiropractic care			All services, with the exception of Emergency Care, are subject to the deductible and coinsurance. Emergency Care coverage is the same as in-network coverage. **Deductible** Individual: $1,000 Family: $2,500 **Coinsurance** Plan pays 80% You pay 20% Subject to balance billing **Max Out-of-Pocket (MOOP)** Individual: $5,000 Family: $12,500
Primary Care Physician Office Visit Includes Family and General Practitioner, Internist, Pediatrician and OB/GYN			
Preventive Care: $0 Includes routine physical, annual gynecological and well childcare exams	**Non-Preventive Care:** $20 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 Electrophysiology Cardiology Interventional Cardiothoracic Surgery Ear, Nose and Throat (ENT)	Endocrinology General Surgery General Surgery – Colon/Rectal Nephrology Neurology Neurosurgery -Spine Ophthalmology	Orthopedics – Hand, Foot/Ankle Hip/Knee Shoulder/Elbow Spine Sports Medicine Pulmonology Rheumatology Urology	
All Other Specialist Office Visits: $20			
Therapy/Rehab: $20 Physical/occupational/speech/ ABA therapy and chiropractic Limited to 25 visits per year for each therapy type. Cardiac Rehab limited to 36 visits per year.			
Acupuncture: $20 Limited to 15 visits per year			
Urgent Care Copay: $25			
Emergency Room Copay: $150 Applies to ER/Observations (Waived if admitted)			

YOUR MEDICAL

United Healthcare

CHOICE PLUS PPO

In-Network		Out-of-Network
SERVICES SUBJECT TO THE DEDUCTIBLE, THEN COVERED 100% See services listed below		All services, with the exception of Emergency Care, are subject to the deductible and coinsurance. Emergency Care coverage is the same as in-network coverage.
Deductible	Individual: $500 Family: $1,250	**Deductible** Individual: $1,000 Family: $2,500
Coinsurance	Plan pays 100% You pay 0%	**Coinsurance** Plan pays 80% You pay 20% Subject to balance billing
Maximum Out-of-Pocket: (MOOP)	Individual: $2,500 Family: $6,250	**Max Out-of-Pocket (MOOP)** Individual: $5,000 Family: $12,500
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		

	In-Network	Out-of-Network
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.

*Participation in the annual ThriveOn Wellness Your Way Program may reduce your out-of-pocket expenses.

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

United Healthcare

CHOICE PLUS PPO

In-Network	Out-of-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	All services, with the exception of Emergency Care, are subject to the deductible and coinsurance. Emergency Care coverage is the same as in-network coverage. **Deductible** Individual: $1,000 Family: $2,500 **Coinsurance** Plan pays 80% You pay 20% Subject to balance billing **Max Out-of-Pocket (MOOP)** Individual: $5,000 Family: $12,500
Nutritional Counseling: 100% Two visits per member per plan year 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	

YOUR MEDICAL

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

Nurseline

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

"My baby has a temperature of 102 degrees. It's midnight. What do I do?"

"I have diabetes. How can I manage my condition and stay healthy?"

"I've been diagnosed with breast cancer. What treatment options are available?"

"I don't have a primary care physician. Can you help me find one?"

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

Maternity Support Program

A healthy pregnancy is the first step to a healthy baby and mother. The Maternity Support Program provides health assessments, customized educational materials, and maternity nurse support throughout your pregnancy. Enrollees in the Maternity Support Program are eligible to receive up to $200: $50 upon enrollment and $150 upon completion of the program (approximately two weeks post-delivery). When United Healthcare becomes aware of your pregnancy, you are mailed a welcome packet inviting you to join the program.

1.888.246.7389

uhc.com/health-and-wellness/health-topics/pregnancy

Neonatal Resource Services

The Maternity Support Program helps to identify high-risk pregnancies. During the last months of your pregnancy and well into the first year of your newborn's life, the Neonatal Resource Services provides nurse consulting services and a Neonatal Centers of Excellence network to help you find the specialized care you and your baby need.

1.888.936.7246

myuhc.com

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

YOUR MEDICAL

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)

YOUR MEDICAL

Bariatric Surgery

Bariatric surgery is a serious, life-changing medical procedure that should be considered as a final step in one's weight loss journey. Coverage eligibility requires a six-month weight loss effort medically documented and supervised by the patient's treating physician with a minimum of one physician visit per month for six consecutive months. Services may include nutritional/dietary counseling, pre-operative screenings, and participation in program support groups. Surgery must be performed by one of the network programs listed below. Surgery is subject to the deductible. Standard copays apply for any pre- or post-operative testing. Additional administrative and counseling charges vary by program. Limited skin excision benefits after surgery may be available.

Mount Carmel Bariatric Program	OhioHealth Weigh Management
614.234.2052	614.443.2584
mountcarmelhealth.com/	ohiohealth.com/weight-management

Gender Identity Disorder

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. Coverage includes psychotherapy, continuous hormone replacement, and surgery to change the genitalia and specified secondary sex characteristics. There are specific and stringent qualifications that must be met to qualify for services including well-documented gender dysphoria, completion of 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.

Health Engagement Nurse

614.974.9234

United Healthcare offers Franklin County Cooperative members an on-site Health Engagement Nurse. The nurse can support members with locating a primary care physician, connect you with programs and plan features and benefits and help with navigating you to benefits when you have a newly diagnosed chronic condition.

YOUR BEHAVIORAL HEALTH

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

<table>
<tr><th rowspan="2">Plan Provision</th><th colspan="2">United Behavioral Health</th></tr>
<tr><th>In-Network</th><th>Out-of-Network</th></tr>
<tr><td>Annual Deductible</td><td>None</td><td rowspan="5">All services* are subject to the deductible and coinsurance.
* Emergency Care coverage is the same as in-network coverage.
Deductible
Individual: $1,000
Family: $2,500
Coinsurance
Plan pays 80%
You pay 20%
Subject to balance billing
Max Out-of-Pocket (MOOP)
Individual: $5,000
Family: $12,500</td></tr>
<tr><td>Coinsurance</td><td>Plan pays 100%
You pay 0%</td></tr>
<tr><td>Maximum Out-of-Pocket (MOOP)</td><td>Individual: $2,500
Family: $6,250</td></tr>
<tr><td>Outpatient</td><td>100% coverage for the first 30 visits/telemedicine
$20 copay for additional visits beyond the first 30 days</td></tr>
<tr><td>Inpatient</td><td>100% coverage for inpatient treatment for mental health or substance abuse</td></tr>
<tr><td>Do copays apply to deductible?</td><td>N/A</td><td>No</td></tr>
<tr><td>Do copays apply to the MOOP?</td><td>Yes</td><td>No</td></tr>
<tr><td>Does the deductible apply to the MOOP?</td><td>N/A</td><td>Yes</td></tr>
<tr><td colspan="3">Amounts applied to the medical deductible and MOOP will also be applied to the behavioral health deductible and MOOP and vice versa.</td></tr>
</table>

Accessing Behavioral Health services

If treatment transitions from EAP 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 andpassword 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 anactual clinician's office.

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

YOUR PRESCRIPTION DRUG

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 you 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+

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

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.	Get up to a 90-day supply of medication at 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.

YOUR PRESCRIPTION DRUG

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** Up to a 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 and high blood pressure medications: Tier 1 or Tier 2	$0	$0	$0
Oral anti-diabetic 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.

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 just beginning 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

In 2022, manufacturer coupons, also known as coupon cards, will no longer apply to your annual out-of-pocket maximum when used for specialty medications.

YOUR PRESCRIPTION DRUG

Generic vs Brand

Always ask your doctor, 'Is there a generic available to treat my condition?'

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**.

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.

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.

YOUR PRESCRIPTION DRUG

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 DENTAL

Cooperative Members* can choose between two dental plans: the PPO and the DMO. As a reminder, adult orthodontia is only covered in the DMO plan. Call or visit the website below to learn more.

1.877.238.6200 **aetna.com**

You have a choice between **TWO** dental plan options:

Aetna Dental PPO	Aetna DMO
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.	**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% after deductible an additional routine cleaning is allowed for expectant mothers	Covered at fixed co-pays See schedule for details
Basic Fillings, Endodontics, Periodontics, Sealants, Oral Surgery, Repair of Crowns, Bridgework or Dentures	80%	70% after deductible	
Major Restorative Crowns, Bridges, Dentures, Implants	80%	60% after deductible	
Annual Maximum Benefit Non-Orthodontic Services*	$1,500	$1,000	
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)	$1,500 Children under 19 only	$1,400 Children under 19 only	

*Preventative services do NOT accumulate toward the Annual Maximum Benefit

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**

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 with out- of-network claims, contact VSP or download a claim form at **vsp.com**.

To locate a network provider:

1.800.877.7195 **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 $40
Optomap (Retinal Screening)	**Every 12 months** $20 copay	**Not covered**
Lenses Single Bifocal Trifocal Lenticular	**Every 12 months** $20 copay for materials for frames and/or lenses Impact Resistant Lenses covered 100% $20 allowance toward Anti-glare coating	**Every 12 months** Reimbursed up to $50 Reimbursed up to $60 Reimbursed up to $70 Reimbursed up to $70
Contact Lenses (Contact lenses provided in lieu of lenses and frames)	**Every 12 months** $150 allowance for contacts Fitting and evaluation capped at $60 and 100% member paid	**Every 12 months** Reimbursed up to $80 Reimbursed up to $175***
Frames Covered Selection	**Every 12 months** $150 allowance (Retail) $57 allowance (Wholesale)	**Every 24 months** Reimbursed up to $30
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.

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

Extra VSP Program Discounts	
Contacts	15% off cost of contact lens exam (fitting and evaluation)
Glasses and Sunglasses	Average 40% savings on other lens enhancements all non-covered lens options 30% 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, EAP, 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.

Enroll today

Log on to the member portal at
mypremiumbill.com

OTHER IMPORTANT INFORMATION

Health Insurance Portability and Accountability Act of 1996 (HIPAA)

The Health Insurance Portability and Accountability Act (HIPAA) provides rights and protections for participants and beneficiaries in group health plans. HIPAA includes protections for coverage under group health plans that limit exclusions for preexisting conditions; prohibit discrimination against employees and dependents based on their health status; and allow a special opportunity to enroll in a new plan to individuals in certain circumstances. HIPAA may also give you a right to purchase individual coverage if you have no group health plan coverage available and have exhausted COBRA or other continuation coverage.

Women's Health and Cancer Rights Act of 1998

As required by the Women's Health and Cancer Rights Act of 1998, we provide benefits under the plan for mastectomy, including reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy (including lymphedema.) If you are receiving benefits in connection with a mastectomy, benefits are also provided for the following covered health services, as you determine appropriate with your attending physician:

- 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; and
- Prostheses and treatment of physical complications of the mastectomy, including lymphedema.

The amount you must pay for such covered health services (including copayments and any annual deductible) are the same as are required for any other covered health service. Limitations on benefits are the same as for any other covered health service.

Statement of Rights Under the Newborns' and 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 issuers 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 more than 48 hours (or 96 hours.)

Summary of Benefits and Coverage (SBC) and Uniform Glossary

Your Summary of Benefits and Coverage (SBC) and Uniform Glossary provide clear, consistent, and comparable information about your health benefits (medical, behavioral health and pharmacy). It is intended to be a document that you can use to compare benefit plans. To obtain a copy of your SBC, go to **BeWell.franklincountyohio.gov** or contact the Franklin County Benefits and Wellness Office.

Medicare Part D Notice

Some participants may receive an annual Medicare Part D notice. This notice provides information about your current credible prescription coverage. The information may be used to help you decide if you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage to the Medicare drug plan you are considering. If you receive a Medicare Part D Notice, please retain this notice as you may be required to produce it if you choose to join a Medicare drug plan.

OTHER IMPORTANT INFORMATION

Agreement regarding acceptance and review of payroll deductions

Pre-tax and post-tax payroll deductions may occur because of enrollment in the various programs offered in the plan and these deductions will automatically adjust in the event of a change in rates or coverage level. Further, it is the employee's responsibility to review their pay advice to ensure the proper amount is deduction and to notify their employee immediately if the deduction is missing or not correct. In the event a deduction is not processed; the employee is personally responsible for paying the deduction amount either to their employer or the Benefits and Wellness Office unless otherwise instructed or risk termination. Further, pre-tax contributions are irrevocable unless a qualifying status change (as directed by the plan) occurs or during annual open enrollment. Post-tax contributions are revocable upon written notice to the Plan.

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.

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.

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 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 Office receiving and approving the required documents.
- ☐ **IMPORTANT: Print a copy of your Confirmation Statement.**
- ☐ **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 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 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 and Wellness Office if you have questions.

Local: **614.525.5750** | Toll-free: **1.800.397.5884**

Email: **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	**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 spouse: • Page 1 **PLUS** signature page if filed hard copy; **OR** • Page 1 **PLUS** Certificate of Electronic Filing **OR** **OPTION 2: Marriage Certificate (court approved certificate or marriage abstract, not license) PLUS ONE of the following to show CURRENT joint tenancy:** • Proof of joint ownership of residence or other real estate; • 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).
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 financial interdependency:** • Joint ownership of real estate property or joint tenancy on a residential lease; • Joint ownership of an automobile; • 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)**
Natural child (up to age 26)	A natural (biological) child of the covered employee or domestic partner. The domestic partner must be enrolled to enroll a natural child of the domestic partner unless there is a legal relationship between the employee and the child, i.e., the child was adopted by the employee, or the employee has legal guardianship of the child.	**ONE (1) of the following OPTIONS:** **OPTION 1:** Covered employee or 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 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 parents name**
Stepchild (up to age 26)	A natural (biological) child of an eligible employee's 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 If submitting spouse's tax return or birth certificate of stepchild, and the spouse is not covered under the employee's plan, documents proving eligibility of the spouse are also required.
Child (up to age 26 for whom the employee, spouse or domestic partner is legal guardian.	A child for whom legal guardianship has been awarded to the covered eligible employee, spouse, or domestic partner. The domestic partner must be covered in order to cover a child for whom the domestic partner has been awarded legal guardianship unless there is a legal relationship between the employee and the child, i.e., the employee has legal guardianship of the child as well.	**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:** Court documents signed by a judge verifying legal custody of the child If submitting spouse's tax return or court documents of legal custody, and the spouse is not covered under the employee's plan, documents proving eligibility of the spouse are also required.

DEPENDENT CHILD

DEPENDENT TYPE	DEFINITION	REQUIRED DOCUMENT(S)
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 covered in order to cover an adopted child of the domestic partner unless there is a legal relationship between the employee and the child, i.e., the child was adopted by the employee as well or the employee has legal guardianship of the child.	**ONE (1) of the following OPTIONS:**
		OPTION 1: Covered employee or 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 submitting spouse's tax return, court documents or adoption papers, and the spouse is not covered under the employee's plan, 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

CHILD OF A DEPENDENT CHILD (I.E. GRANDCHILD)

DEPENDENT TYPE	DEFINITION	REQUIRED DOCUMENT(S)
Child of a dependent child, i.e., grandchild	A child of a dependent child. The child of a dependent child is eligible for coverage only if the dependent is **eligible** and **enrolled** for coverage.	Birth Certificate of child, i.e., of grandchild
		OR
		If the child'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

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 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