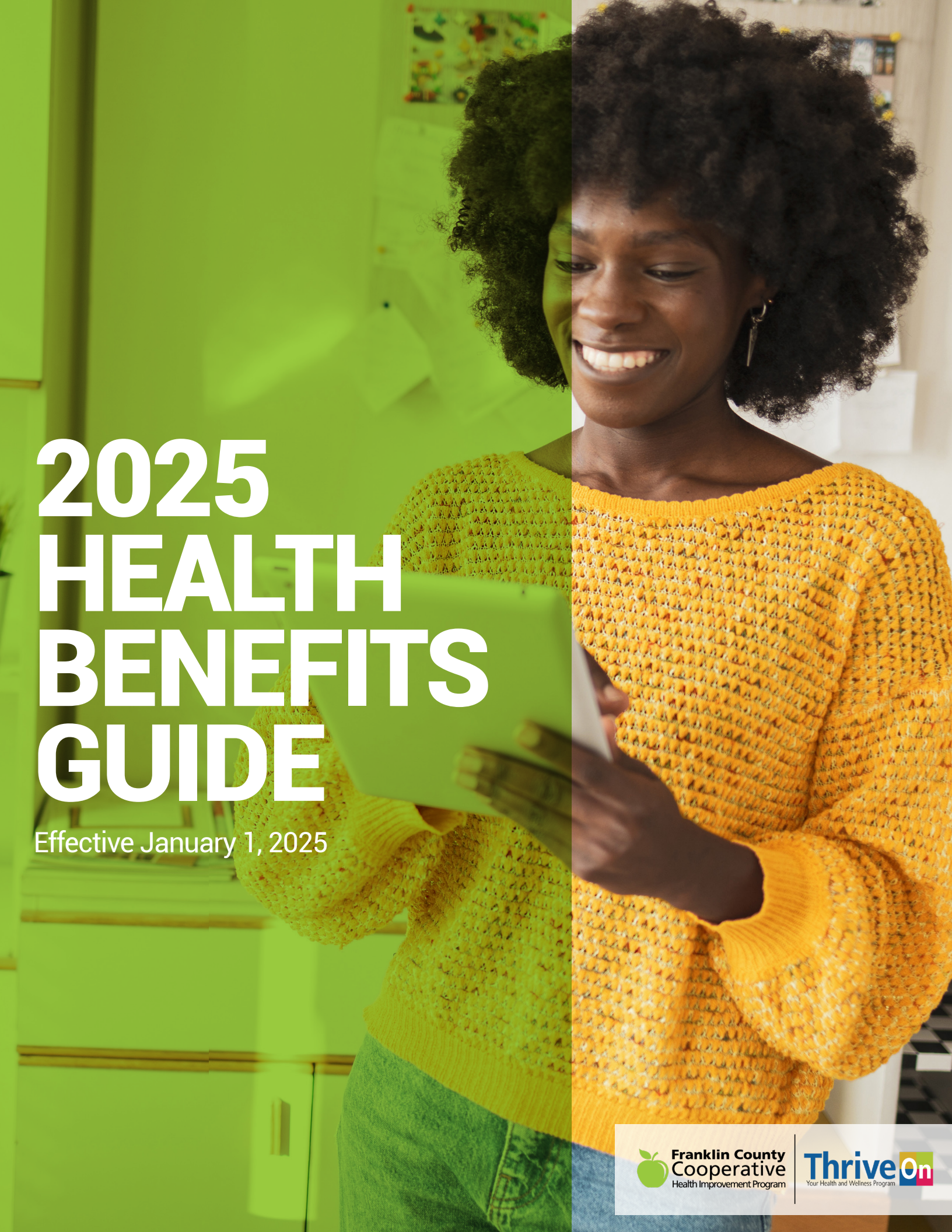
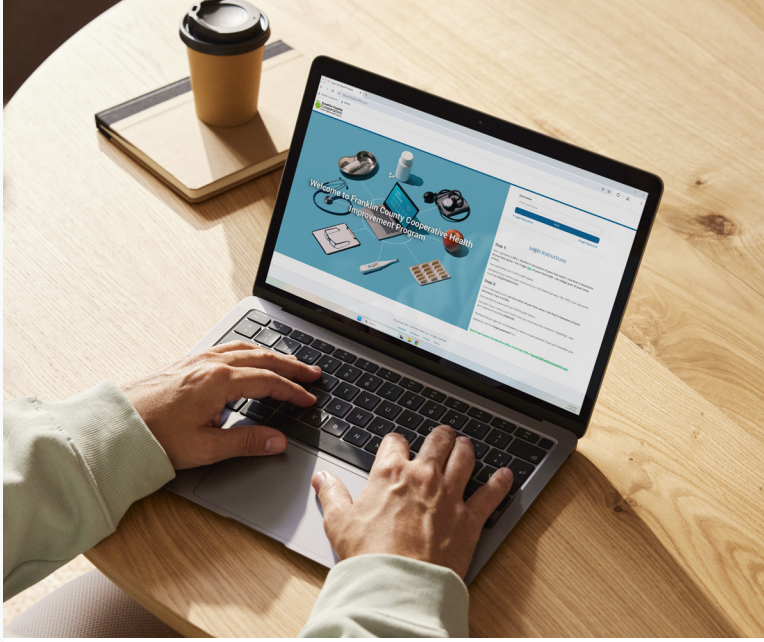


2025 HEALTH BENEFITS GUIDE

Effective January 1, 2025

Franklin County Cooperative Health Improvement Program | ThriveOn Your Health and Wellness Program

CONTENTS



KNOW YOUR BENEFITS

Selecting your benefits is one of the most important decisions you'll make for yourself and your family. Insurance benefits provide essential coverage for many of life's unexpected health events, offering financial protection even when out-of-pocket costs arise.

This guide is here to help you understand your options and how they can work for you. Whether you're exploring benefits for the first time or looking to maximize your current plan, it's crucial to assess your needs thoughtfully. With the right information, you can make informed decisions that safeguard your health, finances, and future.

Qualifying Life Events, such as marriage or the birth of a child allow you to adjust your coverage before the next annual enrollment period. You have 30 days from the date of the event to make changes. Supporting documents are required for adding or removing dependents.

To view your current benefits or report a life event, visit **fccBenefits.com**. For additional information on wellness programs and resources available to you as a Franklin County Cooperative member, visit **BeWell.franklincountyohio.gov**.

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:

1. Legal spouse of employee (same or opposite gender; excludes ex-spouse and legally separated spouse)
2. Domestic partner of employee (cannot be a legal spouse)
3. Child(ren) (see right)
4. 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.*

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/ 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).

Eligibility requirements must be met for any individual for which coverage is requested. In addition, if a covered dependent loses eligibility, it is your responsibility to notify the plan and remove the dependent from your coverage. Upon discovery, the plan will immediately terminate the coverage for any dependent who is ineligible. ***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 DOMESTIC PARTNER AND TAXES

Coverage is available for same and opposite gender domestic partners of employees. The IRS does not recognize domestic partners (or their children) as tax qualified dependents. If you enroll a domestic partner or a domestic partner's child(ren) the IRS rules impact your taxable income as indicated below. Additionally, FSA dollars cannot be used to pay for domestic partner or domestic partner child(ren) expenses.

Tax implications of enrolling a domestic partner:

- **Monthly Contribution:** The amount of your monthly contribution attributable to domestic partner or domestic partner child(ren) coverage is collected post-tax. The amount attributable to you and your tax qualified dependents is collected pre-tax.
- **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. You are encouraged to research your options thoroughly and 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 BENEFIT OPTIONS

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

Employer Paid Benefits

Your employer pays 100% of the cost of these benefits. You do not need to elect these benefits; enrollment is automatic.

- **Basic Life and Accidental Death & Dismemberment Insurance** (AD&D)
    - $50,000 of Basic Life Insurance*
    - $50,000 Accidental Death & Dismemberment (AD&D) Life Insurance*
- **Emotional Wellbeing Solutions**
- **ThriveOn Wellness Your Way**

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

Employee Paid Benefits

Employees pay 100% of the cost of these benefits. You must elect these benefits; enrollment is not automatic. You can elect these benefits even if you decline other benefits.

- **MetLife Legal**
- **Healthcare Flexible Spending Account (FSA)**
- **Dependent Care Flexible Spending Account (FSA)**
- **Additional (Supplemental) Employee, Spouse/Domestic Partner or Child Life Insurance**
- **Short-Term Disability**
- **Long-Term Disability**
- **MetLife Pet Insurance**

Employer and Employee Shared Cost Benefits

Your employer pays the majority of the cost of these benefits. Your employee contribution pays for your portion of the cost of these benefits. You must elect these benefits; enrollment is not automatic. This benefit package includes: Medical, Behavioral Health, Prescription Drug, Dental, and Vision coverage.

These 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?

You will automatically be enrolled in the Employer Paid benefits, even if you decline the Shared Cost benefits. You may elect the Employee Paid benefits, even if you decline the Shared Cost benefits. You must designate life insurance beneficiaries regardless of benefits elected.

YOUR NEW HIRE ENROLLMENT

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

ACCESS THE ENROLLMENT SYSTEM

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

Step 1

Your username is **FCC + the first 3 characters of your first name + the first 3 characters of your last name + the 2 digit DAY of your birth (DD) + the 4 digit year of your birth (YYYY)**.

Your username is all CAPITALIZED letters.

Example: *If your name is John Smith and your birth date is January 15, 1975, your username would be* ***FCCJOHSMI151975****.*

Step 2

Your initial password is ***the first letter of your first name + the first 3 characters of your last name + last 4 digits of your SSN****.*

Your temporary password is all CAPITALIZED letters.

At your first login, you will be asked to establish a permanent password. If at anytime you forget your password, the system offers a password reset option.

All subsequent changes - including Open Enrollment and Qualifying Life Event changes - to your benefit elections must be requested in the self-service enrollment system.

You must enroll within 30 days from your date of hire. Your benefits become effective on the 1st of the month following your date of employment. If you miss this initial enrollment opportunity you must wait until the next Open Enrollment to enroll. 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).
- At least one beneficiary for life insurance.

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

SPECIAL ENROLLMENT NOTICE DUE TO QUALIFYING LIFE EVENTS

If you choose not to enroll yourself or your dependents (including Spouse/Domestic Partner) because you have other health insurance or group health plan coverage, you are able to join the Cooperative's plan later if you or your dependents lose that other coverage (or if the employer stops paying for it). This is considered a Qualifying Life Event.

In addition, if you gain a new dependent due to a Qualifying Life Event (marriage, adoption, placement for adoption, etc.), you may be able to enroll yourself and your dependents if you request enrollment **within 30 days** from the event.

If you do not request enrollment within 30 days of a Qualifying Life Event, you must wait until the next Open Enrollment.

See the Open Enrollment & Life Events section for more information.

OPEN ENROLLMENT

Open Enrollment occurs annually - typically in the fall - and is your opportunity to make changes to who is enrolled in coverage and the benefits you have elected. **Changes are effective January 1st.** A few reminders about Open Enrollment:

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

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

YOUR 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, within 30 days of the Qualifying Life Event or by the published deadline at Open Enrollment. 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:

Upload into the Online Enrollment system:	**fccBenefits.com**
Send documents via post or inter-office mail or hand deliver to:	**Franklin County Benefits & Wellness 373 S. High Street, 25th Floor Columbus, OH 43215**
FAX:	**614.525.5515**
Email:	**Benefits@franklincountyohio.gov**

LIFE EVENTS

Qualifying Life Events are changes that occur outside of Open Enrollment and can affect your benefit needs. Certain events make you eligible to change your benefits before the next annual Open Enrollment. **You have 30 days from the date of a Qualifying Life Event to make changes.** Eligibility documents are required for adding or removing dependents.

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

QUALIFYING 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	The day immediately following the date of the event.	**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 is 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.** Additional documentation may be requested.
Death of Employee	Employee coverage ends the date of death. Dependent coverage continues through the end of same month.	**Copy of the death certificate or obituary.** If a life insurance claim is filed, a life insurance claim form and an original (not a copy) of the death certificate are required.
Death of Dependent	Dependent coverage ends the date of death.	

To request a Qualifying Life Event visit **BeWell.franklincountyohio.gov** > Menu > Life Events. For any questions regarding Open Enrollment & Life Events contact the Benefits & Wellness Office at **Benefits@franklincountyohio.gov**.

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

YOUR STATUS CHANGES FROM PART-TIME OR FULL-TIME

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

YOU TRANSFER TO A NEW AGENCY

If you transfer to a new agency within 30 days 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 the following information, contract your HR/Payroll officer. You cannot make these changes in the enrollment system yourself.

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

YOUR EMPLOYMENT TERMINATION

If your employment terminates:

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

Life insurance continuation options are offered. You will be notified by the carrier of your portability/ conversion options and will have up to 45 days to request portability/conversion. If your employment is reinstated within 30 days or less, there will be no break in coverage. If your break in employment is greater than 30 days, you will be treated as a New Hire.

YOUR QUESTIONS

If you have questions regarding your **eligibility, enrollment, Qualifying 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! Contact information for our current carriers is listed below.

BENEFITS
BENEFITS & WELLNESS OFFICE

614.525.5750 OR **1.800.397.5884**
BeWell.franklincountyohio.gov
Email: Benefits@franklincountyohio.gov

THRIVEON
BENEFITS & WELLNESS OFFICE

614.525.3948
BeWell.franklincountyohio.gov
Email: ThriveOn@franklincountyohio.gov

ONLINE ENROLLMENT SYSTEM
WEX

614.525.5750
fccBenefits.com
Email: Benefits@franklincountyohio.gov
App: Benefitsexpressway

WELLNESS
BENEFITS & WELLNESS OFFICE

1.888.255.0162
fccThriveon.com
Email: ThriveOn@franklincountyohio.gov
App: WebMD Health Services (CODE: OHWELLNESS)

EMOTIONAL WELLBEING SOLUTIONS
OPTUM

1.800.354.3950
liveandworkwell.com (Access Code: EAP)

BEHAVIORAL HEALTH
OPTUM

1.800.354.3950
liveandworkwell.com (Access Code: EAP)

PHARMACY
OPTUMRX

1.855.312.2307
OptumRx.com
App: OptumRx

MEDICAL
UNITEDHEALTHCARE

1.877.440.5983
myuhc.com
App: UHC

FAMILY FORMING
MAVEN CLINIC

mavenclinic.com/join/franklincounty
Help Email: support@mavenclinic.com
App: Maven Clinic

DENTAL
AETNA

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

VISION
VSP

1.800.877.7195
vsp.com
App: VSP

LIFE INSURANCE
THE STANDARD

1.800.378.4668 OR **1.800.628.8600**
www.standard.com

DISABILITY
METLIFE

1.866.729.9201
MetLife.com/MyBenefits
App: MetLife US App

LEGAL
METLIFE

1.800.821.6400
members.legalplans.com
App: MetLife Legal Plans

PET INSURANCE
METLIFE

1.855.934.6153
metlife.com/getpetquote
Help Email: pet_info@metlife.com
App: MetLife Pet

FLEXIBLE SPENDING ACCOUNT
WEX

1.866.451.3399 OR Fax: **866.451.3245**
fccBenefits.com
Email: customerservice@wexhealth.com
App: Benefits by WEX

COBRA
BENEFIT EXPRESS, A WEX COMPANY

1.877.837.5017
mypremiumbill.com
Help Email: help@mybenefitexpress.com

YOUR EMOTIONAL WELLBEING SOLUTIONS (EWS)

Emotional Wellbeing Solutions provides confidential access to care, as well as resources and tools to help keep life balanced. Explore your options for support here — and connect with us for any questions. For everything from anxiety or depression to relationship concerns or job stress to parenting — and more — you have help available to you and your family

EWS is an Employer Paid benefit and available to you as well as any member of your household - even if you aren't enrolled in the health plan. When you call Optum EWS, you'll speak with a master's-level specialist who can offer in-the-moment support and connect you to other resources, such as in-person counseling sessions, if needed.

AVAILABLE EMOTIONAL WELLBEING SOLUTIONS SERVICES

FACE-TO-FACE AND VIRTUAL COUNSELING

Eight visits per problem, per year. A network of clinicians who provide goal-oriented counseling surrounding topics such as depression/anxiety, substance abuse, relationship problems, workplace conflicts, child/eldercare and more.

DIGITAL SELF-CARE TOOLS

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

WORKLIFE SERVICES

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

FINANCIAL COACHING FROM EXPERTS

Up to 60 minutes of free consultation (provided in 30-minute increments) with a credentialed financial coach for each financial issue. Access to extensive legal and financial tools and libraries to help you take control of your finances. For more structured financial coaching, consider the Enrich Financial program.

LEGAL COUNSELING AND MEDIATION SERVICES

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

GET STARTED

Call **1.800.354.3950**, TTY **711**. An EWS specialist will provide an authorization code. Or Visit **liveandworkwell.com** (Access code: **EAP).**

ACCESSING EWS SERVICES

1.800.354.3950

Services MUST BE obtained from a network provider. To locate an EWS clinician, contact Optum at the intake number above or log onto liveandworkwell.com and conduct a provider search. The access code is EAP. Services MUST BE certified. To obtain a certification for services, call Optum at the intake number above before visiting your clinician. You may prefer to obtain a certification online at liveandworkwell.com.

SUBSTANCE USE TREATMENT HELPLINE

1.800.780.7955

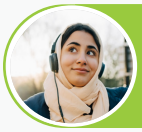
It's hard to acknowledge that you or a loved one may have a problem. You may feel it's a character weakness that needs to be hidden. But alcohol and drug addiction are a condition, and it's treatable. Seeking treatment is the first important step. But understanding different types of treatment and knowing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

SUICIDE PREVENTION HOTLINE

988

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

Connect with the **Emotional Wellbeing Solutions** for free, confidential assistance 24/7.



Find support when you need it with **Onsite EAP Services**.

Call the 24/7 **Substance Use Helpline** for concerns about drug or alcohol use.

Connect with **behavioral health providers** online or in-person.

**Must be enrolled in benefits*

Use 24/7 **Talkspace Online Therapy** for ongoing mental or behavioral health concerns.

Download the **Calm** app to tackle stress, get better sleep, and feel more present.

Build resiliency to better cope with stress through meQuilibrium at **fccThriveOn.com.**

Get support for your to-do list and maintain work-life balance with **WorkLife Services**.

Connect to caring support from a trained crisis counselor with the **988 Suicide & Crisis Lifeline**.

Get **Caregiving Support** for an aging parent.

YOUR THRIVEON WELLNESS PROGRAM

ThriveOn wellness initiatives are tailored to enhance the overall health of Cooperative employees and their enrolled Spouses/Domestic Partners and dependents, addressing mental, emotional, physical, social, and financial aspects of wellness. **The Reduced Deductible is an incentive provided through ThriveOn.**

PROGRAMS AVAILABLE

- **Bloom:** Free, confidential support for parents and caregivers to enhance children's mental well-being.
- **CancerBridge:** Available to all employees and their immediate family members. Whether you or your family member has been newly diagnosed, undergoing treatment, or transitioning into survivorship, CancerBridge is dedicated to offering comprehensive support and guidance throughout their cancer journey.
- **Emotional Wellbeing Solutions:** This program provides confidential support for everyday challenges. These resources are available 24 hours a day, 7 days a week.
- **Enrich Financial:** Personalized 1:1 financial coaching, ensuring you have the support and resources needed to achieve your financial aspirations.
- **Family Forming:** Support and resources for alternative paths to parenthood, including adoption, fertility coverage, virtual support, reimbursement and more.
- **Gym Membership Reimbursement*:** Receive up to $50 per month based on gym attendance. No reimbursement for 0–3 visits, 50% reimbursement (up to $25) for 4–7 visits, and 100% reimbursement (up to $50) for 8 or more visits.
- **Health Coaching*:** The health coaching program, led by WebMD Health and Wellness Coaches, helps you develop a personalized action plan to steadily progress towards achieving your health goals.
- **Health Engagement Nurses*:** UnitedHealthcare nurses provide comprehensive health education, offer ongoing support for chronic conditions, and assist in finding healthcare providers tailored to individual needs.
- **Nutrition Counseling*:** Personalized nutrition advice through UnitedHealthcare medical benefits.
- **Onsite EAP Consultant:** Offers support for mental health and work-life balance and guides you to the resources that best fit your situation.
- **Tobacco Cessation:** Access to trained health coaches, programs to guide you, over-the-counter products through pharmacy benefits.
- **Weight Management Services:** This program includes coverage for weight loss medications and bariatric surgery through your OptumRx pharmacy and/or UnitedHealthcare medical benefits.
- **WeightWatchers*:** Supportive programs and tools for healthy eating and weight management.
- **Wellness Your Way*:** Your overall well-being matters—whether it's physical, emotional, or financial. This program lets you earn up to $1,000 in incentives for taking steps toward your health and wellness goals.
- **YellowBird Meal Kits:** Participants receive a free meal kit with local ingredients and can watch a virtual cooking demo with an OhioHealth dietitian and Yellowbird Foodshed's owner.

**Spouses/Domestic Partners must be enrolled in the health plan to participate in this program.*
Learn about each program in depth at ***BeWell.franklincountyohio.gov/ThriveOn/ThriveOn-Programs***

YOUR LIFE INSURANCE

The following types of life insurance are available, administered through The Standard: **Basic Life**, **Accidental Death & Dismemberment (AD&D)**, and **Supplemental Life**. 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.

Basic Life: Basic group term life that pays a benefit in the event of an employee's death due to illness or injury. This is provided at no cost to the employee.

Accidental Death & Dismemberment (AD&D)*: AD&D coverage pays a benefit in the event of an employee's death or dismemberment resulting from an accident. The amount payable is determined by the loss. This is provided at no cost to the employee. For a full listing of covered losses and corresponding percentages, refer to the life insurance certificate at **BeWell.franklincountyohio.gov**.

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

Supplemental Life: Supplemental life is additional coverage an employee may purchase on the lives of their Spouse/Domestic Partner, eligible dependent children and themselves. Coverage for the employee and Spouse/Domestic Partner may be purchased in $10,000 increments up to the maximum amount allowed. $5,000 or $10,000 of coverage may be purchased for dependent children. Supplemental Life coverage pays a benefit in the event of death due to illness or injury.

THE AD&D BENEFIT ALSO INCLUDES ADDITIONAL BENEFITS FOR THE FOLLOWING:	
Seat Belt Benefit:	$25,000 **OR** 50% of the coverage amount, whichever is less. Payable in the event of death or dismemberment resulting from an automobile accident, provided a seat belt was properly worn at the time of the incident.
Spouse Training Benefit:	25% of coverage amount or a maximum of $5,000 per year, **OR** the cumulative total of $10,000, whichever is less. This benefit covers vocational training, certifications and junior colleges to help a surviving spouse enter or advance in the workforce.
Day Care Benefit:	25% of 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. This benefit covers charges for childcare of dependent children.
Higher Education Benefit:	25% of 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. This benefit covers tuition charges at four-year universities or colleges.
Line of Duty Benefit:	$50,000 **OR** 100% of coverage amount, whichever is less. Payable in the event of death or dismemberment sustained while serving in the line of duty as a public safety officer.
Occupational Assault Benefit:	$25,000 **OR** 50% of coverage amount, whichever is less. Payable if death or dismemberment occurs at work due to an act of physical violence, supported by a police report.
Public Transportation Benefit:	$200,000 **OR** 200% of coverage amount, whichever is less. Payable if death or dismemberment occurs during travel on public transportation (plane, bus, etc.)

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 your insurance, your insurance or increase will not become effective until the day after you complete on full day of active work as an eligible member.

ADDITIONAL/SUPPLEMENTAL LIFE

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

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

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

THINGS TO KNOW ABOUT SUPPLEMENTAL LIFE INSURANCE:

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

GUARANTEE ISSUE (GI)

It is important to understand Guaranteed Issue (GI). GI allows you to enroll yourself, your Spouse/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.

GI EXAMPLES

NEW HIRE

As a new hire, you request $200,000 in life insurance coverage for yourself and $100,000 for your spouse. You are automatically approved for $100,000, and your spouse is approved for $50,000.

For any coverage above the Guaranteed Issue (GI) amounts, the system will notify you that a Medical History Statement (EOI form) is required. You will receive written notice from the life insurance company once they decide to approve or deny the additional coverage.

LIFE EVENT

You are currently enrolled in $50,000 of Additional (Supplemental) Life Insurance, and your spouse has $30,000. After the birth of your baby, you can update your life insurance coverage within 30 days of the event, just like with medical coverage.

You request an additional $100,000 for yourself and $70,000 for your spouse. You are automatically approved for an extra $50,000 (bringing your total to $100,000, the Guaranteed Issue amount), but you will need to submit a Medical History Statement (EOI form) for the remaining $50,000.

Your spouse is automatically approved for an extra $20,000 (bringing their total to $50,000, the GI amount) and will also need to complete a Medical History Statement for the remaining $50,000. You enroll your child for $10,000 in coverage, 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.

TRAVEL RESOURCE SERVICES

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

US/Canada
1.800.872.1414

Other Locations
(collect): **+1.609.986.1234**
(text): **+1.609.334.0807**

medservices@assistamerica.com

THE LIFE SERVICES TOOLKIT

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

1.800.378.5742

Standard.com/mytoolkit
Username: support

PORTABILITY AND CONVERSION OPTIONS

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

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

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

1.800.378.4668

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

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

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

ACTIVE AT WORK PROVISION

You must be actively at work for coverage to become effective. If you are not Actively at Work on the date insurance would otherwise take effect, insurance will take effect on the day you resume Active Work. Actively at Work or Active Work means that you are performing all the usual and customary duties of your job at your regular schedule. This must be done at:

- The Policyholder's place of business.
- An alternate place approved by the Policyholder; or
- A place to which the Policyholder's business requires you to travel

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

THE DISABILITY INSURANCE PROGRAM OFFERS THE FOLLOWING COVERAGE:

SHORT-TERM DISABILITY*

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

LONG-TERM DISABILITY*

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

COMBINING SHORT- AND LONG-TERM DISABILITY

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

POLICY PROVISION	SHORT-TERM DISABILITY INSURANCE	LONG-TERM DISABILITY INSURANCE
Elimination Period: 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.	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
Benefit Amount: 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.	60% of your gross weekly pre-disability earnings	60% of your gross monthly pre-disability earnings
Maximum Benefit Amount^: 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.	$1,500/per week	$10,000/per month
Maximum 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.	26 weeks	Greater of Social Security Normal Retirement Age or 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

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

1. **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.
2. **Vocational Analysis:** Help with identifying job requirements and determining how your skills can be applied to a new or modified job with your employer.
3. **Job Modifications and Accommodations:** Adjustments (i.e., redesign of workstation tools) that enable you to return to work
4. **Retraining:** Development programs to help you return to your previous job or educate you for a new one.

REHABILITATION INCENTIVES TO EASE YOUR BURDEN

1. **Financial Incentive:** Allows you to receive disability benefits or partial benefits while attempting to return to work.
2. **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.
3. **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.
4. **Moving Expense Benefit:** Provides reimbursement for your move to a different address as part of an approved rehabilitation program.

RESOURCES & TOOLS

MyBenefits Website: Access the MyBenefits website at www.metlife.com/mybenefits to get information about an existing disability claim, update claim information, send messages and attachments to MetLife, and receive alerts about your claim status. The website also allows you to sign up for direct deposit for your benefit payments.

- MetLife Disability Claim Online Access

MetLife

Track the status of your disability claim using the MetLife US App, available on the iTunes® App Store and Google® Play. Note that registration on the MyBenefits website is required before using the app.

ANSWERS TO SOME IMPORTANT FREQUENTLY ASKED QUESTIONS ABOUT YOUR DISABILITY PROGRAM

HOW IS 'DISABILITY' DEFINED UNDER THE PLAN?

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

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

CAN AN EMPLOYEE FILE FOR DISABILITY WHILE OUT ON MATERNITY LEAVE?

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

WHAT HAPPENS TO DISABILITY COVERAGE IF YOU LEAVE THE COUNTY?

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

WHAT IF THE EMPLOYEE HAS OTHER SOURCES OF INCOME DURING THE DISABILITY PERIOD?

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

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

CAN AN EMPLOYEE STILL RECEIVE BENEFITS IF YOU RETURN TO WORK PART TIME?

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

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.

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 / LIMITATIONS TO COVERAGE?

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

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

HOW DO YOU ENROLL?

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

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

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

LONG-TERM DISABILITY INSURANCE		
A	Annual Earnings=	
B	Monthly Earnings= (A ÷ by 12)	
C	Value Per $10= (B ÷ by 100)	
D	Enter applicable age-banded rate=	
E	**Estimated Monthly Contribution=** (C x by the applicable age-banded rate D)	

SHORT-TERM DISABILITY INSURANCE	
Age	**Rates per $10 Weekly Benefit**
0-29	$0.282
30-39	$0.278
40-49	$0.316
50-59	$0.479
60-64	$0.629
65+	$0.629

LONG-TERM DISABILITY INSURANCE	
Age	**Rates per $100 Monthly Payroll**
0-29	$0.351
30-39	$0.418
40-49	$0.627
50-59	$0.639
60-64	$0.522
65+	$0.382

YOUR LEGAL PROGRAM

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

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

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

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

This program is voluntary. Employees pay 100% of the post-tax $16.50 per month premium (totaling $198 for the year). By enrolling in this program, you agree to participate for the full plan year.

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

YOUR FLEXIBLE SPENDING ACCOUNT

WHAT IS A FLEXIBLE SPENDING ACCOUNT?

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

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

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

HEALTHCARE FSA *(USED TO PAY FOR HEALTHCARE)*	
Minimum election: $120	You may use this account to pay for health and medical-related care for you and your dependents.
Maximum election: $3,300	
DEPENDENT CARE FSA *(USED TO PAY FOR DEPENDENT CARE, NOT HEALTHCARE)*	
Minimum election: $120	You may use this account to pay for qualifying dependent care expenses, such as daycare, preschool, or elder care. **This account may not be used to cover dependent health or medical-related care**.
Maximum election: $5,000 per family ($2,500 if filing separately)	

FUND AVAILABILITY

If you enroll in the FSA, you will be asked for an annual election. Your annual election is divided into equal amounts and deducted from each pay. Your total **Healthcare FSA** annual election is available to you on January 1st. Rollover amounts (see below) are deposited into your account in April. **Dependent Care FSA** dollars are available to you as they are deducted from your paycheck and deposited into your FSA account.

BENEFITS CARD AND CLAIMS

Dependent Care FSA dollars are available to you as they are deducted from your paycheck and deposited into your FSA account. Use the FSA Benefits Card as you would a banking card. Swiping or charging an eligible transaction automatically removes funds from your FSA account and pays the vendor. You may be required to provide supporting documentation, so it's important you save any accompanying receipts and paperwork.

USE-IT OR LOSE-IT

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

- **FSA Runout:** Allows you to submit claims through March 31st of the following plan year for expenses that were incurred during the previous plan year. Must be submitted via manual claim form.

The IRS does allow the following exceptions to the Use-It or Lose-It rule:

- **Healthcare FSA Rollover:** Lets you carry a portion of your unused funds into the next year. The rollover of funds occurs in April (after the Runout ends). Rollover funds can be used until the end of the year. $640 of unused 2024 funds will rollover from 2024 to 2025. $660 of unused funds will rollover from 2025 to 2026. Funds above the rollover amount are forfeited.
- **Dependent Care FSA Grace Period:** Allows you to use your remaining funds from the current plan year for expenses incurred through March 15 of the following year. After the Grace Period any funds are forfeited.

To learn more about Healthcare and Dependent Care Flexible Spending accounts, including forms and FAQ's go to **BeWell.franklincountyohio.gov**.

YOUR MEDICAL

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

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

	STANDARD	INCENTED
Single Deductible	$500	$200
Family Deductible	$1,250	$500
Coinsurance	100% Covered	100% Covered
Single Out-of-Pocket Maximum	$2,500	$1,000
Family Out-of-Pocket Maximum	$6,250	$2,500

SERVICES SUBJECT TO THE DEDUCTIBLE, THEN COVERED 100%	
Major Diagnostic: CT scans, PET scans, MRI, Nuclear Medicine, etc.	
OTHER SERVICES SUBJECT TO THE DEDUCTIBLE: • Durable medical equipment • Fertility services • Hearing aids • Home health care • Inpatient hospitalization • Inpatient rehabilitation • Major diagnostics • Medical supplies • Outpatient surgery • Prosthetic devices • Skilled nursing facility • Transplantation services	
Do copays apply to the deductible?	No
Do copays apply to the Maximum Out-of-Pocket?	Yes
Does the deductible apply to the Maximum Out-of-Pocket?	Yes
Amounts applied to the medical deductible and MOOP will also be applied to the behavioral health deductible and MOOP and vice versa.	

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

STANDARD OR INCENTED DEDUCTIBLE

STANDARD OR INCENTED DEDUCTIBLE

Your participation in ThriveOn Wellness Your Way determines if you earn the Reduced Deductible Incentive. To see which deductible plan you have earned go to **fccBenefits.com**.

STANDARD PLAN

If you (and your enrolled Spouse/Domestic Partner) **do not complete** the Reduced Deductible Incentive requirements (Online Health Assessment + Annual Physical) by the deadline published at **fccThriveOn.com**, you will be enrolled in the Standard Plan for the following plan year.

In-Network Medical (2025 Standard Plan)		
	Single	**Family**
Deductible	$500	$1,250
Coinsurance	100%	100%
Out-of-Pocket Maximum	$2,500	$6,250

In-Network Behavioral Health (2025 Standard Plan)		
	Single	**Family**
Deductible	$0	$0
Coinsurance	100%	100%
Out-of-Pocket Maximum	$2,500	$6,250

INCENTED PLAN

If you (and your enrolled Spouse/Domestic Partner) **do complete** the Reduced Deductible Incentive requirements (Online Health Assessment + Annual Physical) by the deadline published at **fccThriveOn.com**, you will be enrolled in the Incented Plan for the following plan year.

In-Network Medical (2025 Incented Plan)		
	Single	**Family**
Deductible	$200	$500
Coinsurance	100%	100%
Out-of-Pocket Maximum	$1,000	$2,500

In-Network Behavioral Health (2025 Incented Plan)		
	Single	**Family**
Deductible	$0	$0
Coinsurance	100%	100%
Out-of-Pocket Maximum	$1,000	$2,500

New hires (starting on or after July 1) automatically get a reduced deductible for their first full plan year. To keep it the following year, they must meet the Reduced Deductible Incentive requirements during their first year of coverage.

IN-NETWORK COPAY AMOUNTS

SERVICES SUBJECT TO A COPAY

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

PRIMARY CARE PHYSICIAN OFFICE VISIT
Includes Family and General Practitioner, Internist, Pediatrician and OB/GYN

Preventive Care: $0
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
- 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/pulmonary rehab

- 75 combined total visits for PT/OT/ST
- Unlimited visits per year for post-cochlear implant aural therapy
- Pulmonary rehab limited to 25 visits per year.
- Cardiac rehab limited to 36 visits per year.

Kaia: $0
Available 24/7

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

Urgent Care Copay: $25

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

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

For Out-of-Network coverage, see the Summary of Benefits and Coverage (SBC) or Summary Plan Description (SPD)

IN-NETWORK 100% COVERAGE CATEGORIES

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)
- Breast feeding support, supplies (including rental or purchase cost if obtained from a network physician, hospital or durable medical equipment (DME) provider) and counseling
- Screenings for Domestic Violence, Gestational Diabetes, and Human immune-deficiency virus (HIV) screening/counseling
- Sexually transmitted infection counseling
- Pap Smear
- Prenatal care (Delivery and high-risk prenatal services are covered but not under Women's Preventive Care)
- Contraception methods (including Mirena, Implanon, Nexplanon, Paragard IUDs, Depo Provera injections, diaphragm, Femcap and Tubal Ligation)
- Human papillomavirus (HPV) testing (beginning at age 30 and every 3 years thereafter)
- Mammogram and Digital Breast Tomosynthesis (DBT)/2D/3D/Ultrasound

Nutritional Counseling: 100% Unlimited visits at a UnitedHealthcare in-network dietitian or nutritionists	**Minor Diagnostic:** 100% Minor x-rays, blood draw, lab work, EKG, EEG, ultrasound, etc.
Surgical Procedures in a Physician's Office: 100% Examples include mole removal, stitches, casts, etc.	**Therapeutic:** 100% Chemotherapy, dialysis, radiation oncology, IV infusion, etc.
Virtual Visits: 100% See and talk to a doctor from your mobile device or computer proficiency	***Diabetic Pumps and Supplies:** 100% Diabetic supplies and pumps purchased through the medical plan are covered 100%

For Out-of-Network coverage, see the Summary of Benefits and Coverage (SBC) or Summary Plan Description (SPD)
**Refer to Pharmacy Coverage for purchases through pharmacy*

GETTING THE BEST CARE

The UnitedHealthcare 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.

TIER 1 PHYSICIANS

Physicians in 16 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**.

- Allergy
- Cardiology
- Ear, Nose, and Throat
- Endocrinology
- Family Medicine
- Gastroenterology
- General Surgery
- Internal Medicine
- Nephrology
- Neurology
- Neurosurgery, Orthopedics and Spine
- Obstetrics and Gynecology
- Pediatrics
- Pulmonology
- 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.

VIRTUAL SECOND OPINIONS

2nd.MD connects you with leading physicians in more than 120 subspecialties who can give you trusted information, whether you're trying to choose between treatment options or understand a diagnosis.

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 UnitedHealthcare 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.

NURSELINE

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

DISEASE MANAGEMENT

The Disease Management program supports members in managing their health by reinforcing physician treatment plans, preparing members for effective physician visits, and reducing unnecessary procedures, complications, and emergency needs. It empowers members to improve self-care, recognize warning signs, and access essential resources, enhancing outcomes for conditions such as asthma, COPD, coronary artery disease (CAD), diabetes, congestive heart failure (CHF), and cancer.

UNITEDHEALTHCARE ALLIES

UnitedHealthcare 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
- 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)

KAIA

Access to digital therapy programs for back, neck, and joint pain. The program includes exercises, educational content, and personalized coaching to help manage and alleviate pain.

DISPATCH HEALTH

Get urgent medical care in your home. DispatchHealth delivers urgent medical care to your doorstep and can treat most non-life-threatening injuries or illnesses. Open from 8 a.m. - 10 p.m., 365 days a year, holidays included.

1.866.970.9287

DispatchHealth.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

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

2ND MD

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

1.888.936.7246

myuhc.com

SPECIALIST MANAGEMENT SOLUTIONS

Specialist Management Solutions (SMS) is an exclusive end-to-end approach to Musculoskeletal care (MSK). OHS assists with a wide range of MSK issues, from hands to backs.

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

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

Participation in OHS is voluntary but is very strongly encouraged. Members can self-refer into the program or OHS may reach out to you and invite you to enroll. OHS manages a full range of orthopedic conditions:

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

1.888.936.7246

myuhc.com

GENDER DYSPHORIA

Gender Dysphoria is a condition in which there is a marked incongruence between an individual's experienced/expressed/alternative gender and assigned gender (DSM-5-TR). Gender-affirming care encompasses a range of social, psychological, behavioral, and medical interventions to support an individual's gender identity. Treatment options include behavioral therapy, psychotherapy, hormone therapy, and surgery for gender transformation. Surgical treatments for Gender Dysphoria may include the following: clitoroplasty, hysterectomy, labiaplasty, mastectomy, orchiectomy, penectomy, phalloplasty or metoidioplasty (alternative to phalloplasty), placement of testicular and/or penile prostheses, salpingo-oophorectomy, scrotoplasty, urethroplasty, urethroplasty, vaginectomy, vaginoplasty and vulvectomy.

Other terms used to describe surgery for Gender Dysphoria include gender affirming surgery, sex transformation surgery, sex change, sex reversal, gender change, transsexual surgery, transgender surgery, and sex reassignment.

Coverage includes psychotherapy, continuous hormone replacement, surgery to change the genitalia and specified secondary sex characteristics, breast augmentation, voice/speech therapy/training, tracheal shave, and facial feminization. Specific and stringent qualifications must be met to qualify for services, including completing at least 12 months of continuous hormone therapy without contradictions, and at least 12 months of successful continuous full-time, real-life experience in the desired gender. The treatment plan must conform to identifiable external sources, including the World Professional Association for Transgender Health Association (WPATH) standards and/or evidence-based professional society guidance. Surgery is subject to the deductible. Standard copays apply for office visits.

BARIATRIC RESOURCE SERVICES (BRS)

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

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

1.888.936.7246, TTY 711

myuhc.com

YOUR BEHAVIORAL HEALTH

If you're enrolled in the health plan, you have access to behavioral health benefits for services that go beyond the short-term support provided by the Emotional Wellbeing Solutions or EWS. Your behavioral health benefits are provided through **United Behavioral Health.** These benefits cover a wide range of services from both in-network and out-of-network providers.

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

UNITED BEHAVIORAL HEALTH
In-Network

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

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

For Out-of-Network coverage, see the Summary of Benefits and Coverage (SBC) or Summary Plan Description (SPD)

ACCESSING BEHAVIORAL HEALTH SERVICES

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

YOUR VIRTUAL VISITS

Virtual Visits (VV) make it easy and affordable to get the care you need—when and where it works best for you. Skip the waiting room and connect with a doctor or therapist from home, work, or wherever you are. Take a look at the table below to explore your Virtual Visit options for Medical and Behavioral Health.

	MEDICAL VIRTUAL VISITS	BEHAVIORAL VIRTUAL VISITS
Where do I begin?	myUHC.com or UnitedHealthcare app Find Care & Costs > Virtual Care	liveandworkwell.com Find Expert Care > Search for a Provider > Virtual
Do I need to register a username and password on the website to use VV?	Yes	Yes
What is my cost for a VV?	$0	$0
When should I use VV?	For minor illness: • Allergies • Pink eye • Bladder infection • Cough/cold • Sinus problems • Diarrhea • Seasonal flu • Stomachache, • Prescription medications (per state rules)	For general concerns: • Depression • Anxiety • General therapy • Prescription medications (per state rules)
What equipment or technology do I need?	High speed internet connection (cable, DSL), desktop/laptop/tablet/mobile device with camera/video capability	High speed internet connection (cable, DSL), desktop or laptop (some providers support use of tablet/mobile device) with camera/video capability
Who can use this service?	Anyone covered by your health plan	Anyone covered by your 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. If you have questions about either option, please contact the Onsite EAP and Health Engagement Nurse Support Line at **614.525.6773.**

YOUR PHARMACY COVERAGE

Employees enrolled in the medical plan will automatically receive prescription drug coverage through **OptumRx**. You will receive a prescription drug card to be used at participating pharmacies. Franklin County Cooperative Health Improvement Program offers mail order through OptumRx. Both retail and mail order options are available. You save both time and money by obtaining your ongoing routine prescriptions through the Mail Order Program. You can also save on your copay expense by using generic medications.

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

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

A $4,000 individual and $10,000 family Maximum Out-of-Pocket limit applies to pharmacy coverage.

RETAIL AT YOUR LOCAL PHARMACY VS MAIL ORDER THROUGH HOME DELIVERY

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

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

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

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 (generic)	$5	$10/$15	$12.50
Tier 2 (formulary or preferred brand)	$25	$50/$75	$62.50
Tier 3 (non-formulary or non-preferred brand)	$50	$100/$150	$125
Brand with Generic Available	$50 +	$100+/$150 +	$125 +

DIABETIC SUPPLIES, INJECTABLE 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: Tier 1 or Tier 2	$0	$0	$0
Oral anti-diabetic: 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.

PHARMACY COPAYS AND 100% COVERAGE

PAXLOVID AND TAMIFLU

The copay for Paxlovid, a prescription treatment for mild-to-moderate COVID-19 in adults who are at high risk, and Tamiflu, a prescription treatment for adults and children with flu symptoms, is $5.

ADDITIONAL $0 COPAY MEDICATIONS

The list of Tier 1 and Tier 2 medications for which a member pays a $0 copay is listed below.

- Anti-diabetics (injection and oral)
- Anti-cholesterol
- Anti-blood pressure
- Anti-coagulants
- Glycosides
- Anti-depressants
- Anti-anxiety
- Estrogen/estrogen combos
- Entresto
- Anti-anginals

Additionally, the following preventive medications are 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 (to prevent cardiovascular disease in individuals at high risk, prior authorization required)
- **Birth Control:**
  - **Hormonal:** All Tier 1 (generic) birth control pills as well as some brand name
  - **Transdermal Patch:** Ortho Evra
  - **Emergency:** All Tier 1 (generic) and Ella
- **Cancer:** Tamoxifen and Raloxifene (to prevent breast cancer, prior authorization required)

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**	90-day supply
Tier 1 (generic)	$5	$12.50
Tier 2 (formulary or preferred brand)	$25	$62.50
Tier 3 (non-formulary or non-preferred brand)	10% of cost up to $150 per script	10% of cost up to $300 per script

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

COPAY CARD ACCUMULATOR ADJUSTMENT PROGRAM

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

GENERIC VS BRAND

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

GENERIC EQUIVALENT VS GENERIC ALTERNATIVE

Brand name drugs may have generic equivalents and generic alternatives.

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

MANDATORY GENERIC AND DISPENSE AS WRITTEN

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

FORMULARY OR PREFERRED DRUG LIST

Your formulary, also known as a preferred drug list, is a recommended list of brand name and 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.

Access your formulary online at **OptumRx.com** or **BeWell.franklincountyohio.gov**.

STEP THERAPY

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

STEP THERAPY DRUGS ARE GROUPED IN CATEGORIES:

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

  Step Therapy requires members who are beginning to take Step Therapy drugs for the first time to try the Frontline drug first.
- **Retail Pharmacy:** If you present a prescription for a Back-up drug at your local pharmacy, the pharmacist alerts you of the requirement to use a Frontline drug first. Your pharmacist may or may not offer to contact your physician's office to discuss your options. It is recommended that you discuss your options with your physician. For the pharmacy to dispense a Frontline medication, your physician must write a new prescription or call in a new prescription to the pharmacy.
- **Mail Order:** Similarly, if you submit a prescription for a Back-up drug at the mail order pharmacy, OptumRx informs you that they cannot fill the script as written. They then reach out to your physician to discuss your options. Again, it is recommended that you contact your physician's office.

  After multiple attempts, if OptumRx receives no response from your physician's office, the written prescription is returned to you with a letter of explanation.

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

YOUR FAMILY FORMING

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

MATERNITY BENEFITS

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

MATERNITY SUPPORT PROGRAM

The Maternity Support Program, offered through UnitedHealthcare, provides personalized guidance from experienced maternity nurses. These nurses offer valuable insights into maintaining healthy pregnancy habits and provide educational resources every step of the way. There is no cost to join the program and completing it qualifies you for a $200 incentive. For further details about the Maternity Support Program, contact the number on the back of your UnitedHealthcare ID card: **1.877.440.5983**.

DOULA COVERAGE

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

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

FERTILITY COVERAGE

F**ertility Solutions Plus** offers virtual preconception resources from Maven and support from experienced fertility nurses through UHC. You can access support for all pathways to parenthood including preconception and fertility treatment, adoption and surrogacy. All available to you as part of your health benefits at no additional cost.

- **Personalized Support:** A Maven Care Advocate connects you to family-building resources and virtual support.
- **Clinical Guidance:** UHC fertility nurses provide treatment information and help you find in-person care at Fertility Centers of Excellence (COEs).
- **24/7 Virtual Access:** It's designed to be easy to sign up, book appointments, and explore a library of virtual classes.

The health plan covers fertility treatments and fertility medication for covered employees and/or Spouses/ Domestic Partners. Coverage is only available if services are received from in-network providers. Applicable annual deductibles, coinsurance, and annual out-of-pocket maximums apply and the combined **lifetime maximum benefit for all medical and pharmacy expenses is $30,000 per eligible member**. Services covered under the medical and pharmacy benefits include:

- **Medical:** Fertility preservation, IUI/IVF, associated donor medical expenses, and egg retrieval/storage
- **Pharmacy:** Fertility medication

While not mandatory, it is strongly recommended that Maven is engaged when utilizing these services. Learn more about Maven on the following page.

MAVEN SUPPORT

Maven is a comprehensive virtual support program tailored to meet the needs of you and your family. It's tailored to complement your maternity and fertility benefits, operating independently from UnitedHealthcare. Despite this separation, Maven seamlessly collaborates with your coverage to deliver personalized care throughout the journey from preconception to postpartum. It is also your path to Maven Wallet, which offers support and reimbursement for the acquisition of donor materials, adoption, and surrogacy.

MAVEN WALLET

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

Note: *Maven Wallet cannot provide tax advice. It is strongly recommended that you consult with your personal tax advisor to discuss your personal tax implications related to this benefit. This is a separate benefit than the $30,000 provided for fertility services. This is not a UnitedHealthcare program. Maven Wallet administers this program and enrollment in Maven is mandatory.*

FERTILITY WALLET

Employees enrolled in the health plan are provided a **$10,000 lifetime maximum benefit** per household for acquisition of donor materials not covered under the health plan including materials obtained from a cryo-bank.

ADOPTION AND SURROGACY WALLET

Employees enrolled in the health plan are provided a **$30,000 lifetime maximum benefit** per household for adoption and surrogacy services.

NEONATAL RESOURCE SERVICES

UnitedHealthcare's Neonatal Resource Services offer invaluable support by connecting you with a dedicated neonatal nurse. These nurses are available to address your inquiries and assist you in coordinating with the Neonatal Intensive Care Unit (NICU). They help develop a plan for bringing your baby home, ensuring you have access to necessary services, equipment, and local resources. For further details about this program, please reach out to UnitedHealthcare using the contact number provided on the back of your UnitedHealthcare identification card: **1.877.440.5983**.

LACTATION SUPPORT AND BREASTFEEDING

- **Lactation support and counseling:** Covered by UnitedHealthcare, available through in-network doctors or healthcare professionals. Contact the number on the back of your UnitedHealthcare ID card (**1.877.440.5983**) for more information.
- **Breast pumps:** Purchases of personal electric breast pumps are covered. Contact an in-network doctor or approved breast pump supplier for more details. For a list of in-network breast pump suppliers call the number on the back of your UnitedHealthcare ID card (**1.877.440.5983**).
- **Breast milk storage bags:** Covered at in-network providers. Contact the number on the back of your UnitedHealthcare ID card (**1.877.440.5983**) for more information.

POSTPARTUM SUPPORT

OhioHealth Fourth Trimester Clinic: If you're having concerns with breastfeeding, high blood pressure or postpartum mood disorders, OhioHealth's Fourth Trimester Clinic can help. Located inside the Women's Health Outpatient Center at OhioHealth Dublin Methodist Hospital, this clinic is the first of its kind in the area. For more information, visit **OhioHealth.com/Fourth-Trimester-Clinic.**

Enrollment in Maven is confidential and free to employees and Spouses/Domestic Partners enrolled in the health plan. Activate your free membership by downloading the Maven Clinic app or visiting **mavenclinic.com/join/franklincounty**.

YOUR DENTAL

Franklin County Cooperative Health Improvement Program offers dental coverage administered through Aetna. Employees have a choice between two dental plan options - Dental PPO or DMO. The dental DMO - Dental Maintenance Organization - only provides in-network coverage. The dental PPO - Preferred Provider Organization - provides both in-network and out-of-network coverage. The use of in-network providers reduces out-of-pocket expenses.

YOU HAVE A CHOICE BETWEEN TWO DENTAL PLAN OPTIONS:

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

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

YOUR VISION

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

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

YOUR COVERAGE WITH A VSP PROVIDER			
WELLVISION EXAM	Focuses on your eyes and overall wellness	$0 Copay	Every 12 months
ESSENTIAL MEDICAL EYE CARE	• Additional exams and services beyond routine care to treat immediate issues from pink eye to sudden changes in vision or to monitor ongoing conditions such as dry eye, diabetic eye disease, glaucoma, and more. • Coordination with your medical coverage may apply. Ask your VSP network doctor for details.	$0 Copay	Available as needed

	In-Network	Out-of-Network
Exams	**Every 12 months** $0 copay	**Every 12 months** Reimbursed up to $45
Optomap *(Retinal Screening)*	**Every 12 months** $0 copay	Not covered
Lenses *(Single, Bifocal, Trifocal)*	**Every 12 months** $20 copay Impact Resistant Lenses covered 100% VSP EasyOptions (included in prescription glasses)	**Every 12 months** Reimbursed up to $30 Reimbursed up to $50 Reimbursed up to $65
Contact Lenses* *(Contact lenses provided in lieu of lenses and frames)*	**Every 12 months** $180 allowance for contacts Fitting and evaluation capped at $20 and 100% member paid.	**Every 12 months** Reimbursed up to $105
Frames *(Covered Selection)*	**Every 24 months** $180 allowance (Retail) $57 allowance (Wholesale)	**Every 24 months** Reimbursed up to $70
Child Frames *(Under age 12)*	**Every 12 months**	**Every 12 months**

VSP EASYOPTIONS

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

- Anti-glare Lenses
- Progressive Lenses
- Light-reactive Lenses

EXTRA VSP PROGRAM DISCOUNTS

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

YOUR COBRA

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

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

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

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

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

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

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

HOW DO YOU ENROLL?

Log on to the member portal at **mypremiumbill.com**

NOTICES & OTHER INFO

SPECIAL ENROLLMENT NOTICE

If you do not to enroll yourself or your dependents (including Spouse/Domestic Partner) in the Franklin County Cooperative's coverage because you already have coverage through a different provider/employer, you (or your Spouse/Domestic Partner) may be eligible to enroll in the Franklin County Cooperative's coverage later if you lose eligibility through that provider/employer. **You must contact and request enrollment from the Franklin County Benefits & Wellness Office within 30 days of the loss of other coverage.**

1095 FORM

A 1095 form is provided to you annually. It illustrates if your coverage meets Affordable Care Act (ACA) guidelines. You are not required to provide this form when filing your taxes; however, your tax preparer or advisor may ask to see it.

W-2 HEALTHCARE COSTS

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

WOMEN'S HEALTH & CANCER RIGHTS ACT

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

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

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

NOTICE FOR NEWBORN MOTHERS HEALTH PROTECTION ACT

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

MEDICARE PART D NOTICE

A Medicare Part D Creditable Coverage Disclosure Notice is provided each October to any member enrolled in the health plan (available at **BeWell.franklincountyohio.gov**). This document may be needed when enrolling in a Medicare drug plan. Generally, Medicare is available for people age 65 or older, younger people with disabilities and people with End Stage Renal Disease (permanent kidney failure requiring dialysis or transplant).

HIPAA PRIVACY NOTICE TO EMPLOYEES

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

AGREEMENT REGARDING ACCEPTANCE AND REVIEW OF PAYROLL DEDUCTIONS

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

NOTICE OF EMPLOYER SPONSORED WELLNESS PROGRAM

Personally identifiable information (PII) may be collected when participating in certain ThriveOn wellness activities. This information is maintained and protected at all times and used only for the purpose for which it is gathered. **The Notice of Employer Sponsored Wellness Program** sets forth how information is protected and used.

WHEN A COVERED PERSON QUALIFIES FOR MEDICARE

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

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

WHO PAYS FIRST?

Coordination of Benefits (COB)

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

EXHIBIT 1

ENROLLING AN INELIGIBLE DEPENDENT AND/OR FAILURE TO REPORT THE LOSS OF ELIGIBILITY OF A DEPENDENT ON YOUR PLAN IS CONSIDERED FRAUD AGAINST THE PLAN AND IS PUNISHABLE UP TO AND INCLUDING TERMINATION OF EMPLOYMENT.

DEFINITIONS AND REQUIRED DOCUMENTS CHECKLIST

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

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

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

If the required documents are not provided within this time frame, 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**.
- ☐ **IMPORTANT:** Print a copy of your Confirmation Statement.
- ☐ Refer to the dependent types in the following chart. Identify the documents required.
- ☐ Submit copies of the required documents. **Do not** submit originals.
- ☐ Record the following information in the upper right corner of each document. Employee name and telephone number.
- ☐ Submit the required documents to Franklin County Benefits & Wellness. Documents must be received within the time frames illustrated above.

Upload to Online Enrollment System:	**fccBenefits.com**
Fax:	**614.525.5515**
Email:	**Benefits@franklincountyohio.gov**
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**

Contact Franklin County Benefits & Wellness if you have questions.
614.525.5750 | Benefits@franklincountyohio.gov

SPOUSE AND DOMESTIC PARTNER

DEPENDENT TYPE	DEFINITION	REQUIRED DOCUMENT(S)
Spouse	Legal spouse of a covered employee: • By marriage • Common Law marriage as defined by ORC §3105.12. Does <u>not</u> include: • Ex-spouse • Legally separated spouse	**ONE (1) of the following OPTIONS:** **OPTION 1: Marriage Certificate or Marriage Abstract** • Certified/Court approved certificate or abstract • Marriage license **not** acceptable • Church-issued certificates **not** acceptable **PLUS** **<u>ONE (1)</u>** of the following documents to show CURRENT tenancy (unless married within 12 months of submission): • First page of the covered employees most recent 1040 Federal Tax Return listing the spouse; • Joint ownership of real estate property or joint tenancy on a residential lease; — *Mortgage Statement within 6 months* — *Municipality/County Property Tax within 12 months* — *Mortgage Interest Statement within 12 months* — *Homeowners or Renters Insurance Statement within 12 months* — *Warranty Deed within 6 months* — *Active Lease Agreement (Must show lease begin and termination date.)* • Auto Loan Statement within 6 months; • Bank Statement/Bank Letter within 6 months; • Any Credit Card Statement within 6 months; • Brokerage Statement within 6 months; • Utility bill listing both covered employee and spouse within last 6 months (or 2 separate utility bills at the same address, one listing the covered employee and one listing the spouse); • Designation of the spouse as a primary beneficiary of the covered employee's life insurance policy, retirement plan, or will. **OR** **OPTION 2:** Covered employee's most recent Tax Return Transcript (within last 2 years) issued by the IRS listing the spouse. • Tax Return Transcripts are available thorough the IRS through postal mail or online. Creation of an ID.me account is required for online requests.

SPOUSE AND DOMESTIC PARTNER

DEPENDENT TYPE	DEFINITION	REQUIRED DOCUMENT(S)
Spouse	Legal spouse of a covered employee: • By marriage • Common Law marriage as defined by ORC §3105.12. Does <u>not</u> include: • Ex-spouse • Legally separated spouse	**OR** **OPTION 3 (Common Law Spouse):** Three (3) of the following documents: • One (1) of the following documents dated **prior to October 10, 1991**. — *Joint ownership of real estate property or joint tenancy on a residential lease;* — *Auto Loan Statement;* — *Bank Statement/Bank Letter;* — *Any Credit Card Statement;* — *Brokerage Statement;* — *Designation of the common law spouse as primary beneficiary of the covered employee's life insurance policy, retirement policy, or will.* — *A durable power of attorney signed to the effect that the covered employee and the common law spouse have granted powers to one another.* • Two (2) of the following documents: One (1) document must show CURRENT financial interdependency; and one (1) document must show CURRENT joint tenancy. — Joint ownership of real estate property or joint tenancy on a residential lease; • *Mortgage Statement within 6 months* • *Municipality/County Property Tax within 12 months* • *Mortgage Interest Statement within 12 months* • *Homeowners or Renters Insurance Statement within 12 months* • *Warranty Deed within 6 months* • *Active Lease Agreement (Must show lease begin and termination date.)* • Auto Loan Statement within 6 months; • Bank Statement/Bank Letter within 6 months; • Any Credit Card Statement within 6 months; • Brokerage Statement within 6 months; • Designation of the spouse as a primary beneficiary of the covered employee's life insurance policy, retirement plan, or will.
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 person for 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** **<u>THREE (3)</u>** of the following documents to illustrate at least six (6) months of financial interdependency. All three (3) documents must be within 12 months AND date back at least six (6) months PRIOR to submission. • Joint ownership of real estate property or joint tenancy on a residential lease: — *Mortgage Statement* — *Municipality/County Property Tax* — *Mortgage Interest Statement* — *Mortgage or Home Owners or Renters Insurance Statement* — *Warranty Deed* — *Active Lease Agreement (Must show lease begin and termination date.)* • Auto Loan Statement • Bank Statement/Bank Letter • Any Credit Card Statement • Brokerage Statement • A durable power of attorney signed to the effect that the covered employee and the domestic partner have granted powers to one another. • Designation of the domestic partner as a primary beneficiary of the covered employee's life insurance policy, retirement plan, or will.

DEPENDENT CHILD

DEPENDENT TYPE	DEFINITION	REQUIRED DOCUMENT(S)
Natural Child (Up to age 26)	A natural (biological) child of the covered employee.	Birth Certificate of child **OR IF ADDING A NEWBORN (WITHIN 6 MONTHS OF BIRTH)** ONE (1) of the following: • Hospital release papers on hospital letterhead • Footprints • Crib Card • Letter from physician or hospital on respective letterhead **Documents must include child's DOB and name of covered employee.**
Stepchild (Up to age 26)	A natural (biological) child of an eligible employee's spouse, i.e., a stepchild of the covered employee.	Birth Certificate of stepchild If the spouse is not covered under the employee's plan, documents proving eligibility of the spouse are also required.
Domestic Partner Child (Up to age 26)	A natural (biological) child of the covered domestic partner. The domestic partner must be enrolled to enroll a 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 as well.	Birth Certificate of domestic partner child
Child (Guardianship) (Up to age 26)	A child for whom legal guardianship has been awarded to the eligible employee, spouse, or covered 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.	Court documents signed by a judge verifying legal custody of the child. If submitting document for a child whom legal custody has been awarded to the spouse, and the spouse is not covered under the employee's plan, documents proving eligibility of the spouse are also required.
Adopted Child (Up to age 26)	A legally adopted child of the eligible employee, spouse, or covered 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:** Court documents for the adopted child from a court of competent jurisdiction. **OPTION 2:** International adoption papers from country of adoption. **OPTION 3:** Papers from the adoption agency showing intent to adopt. If submitting documents for an adopted child of the spouse, and the spouse is not covered under the employee's plan, documents proving the 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). The domestic partner must be covered in order to cover a QMCSO child of the domestic partner.	**ONE (1) of the following OPTIONS:** **OPTION 1:** Court documents signed by a judge. **OPTION 2:** Medical support orders issued by a State agency. If submitting documents for a QMCSO child of the spouse and the spouse is not covered under the employee's plan, documents proving the eligibility of the spouse are also required.

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 **OR IF ADDING A NEWBORN (WITHIN 6 MONTHS OF BIRTH)** 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 name of covered dependent as the parent.**

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. The domestic partner must be covered in order to cover a disabled dependent of the domestic partner.	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 If submitting documents for a disabled dependent of the spouse and the spouse is not covered under the employee's plan, documents proving the eligibility of the spouse are also required.

STILL HAVE QUESTIONS?

Contact Us:

BENEFITS
614.525.5750
Benefits@franklincountyohio.gov

THRIVEON
614.525.3948
ThriveOn@franklincountyohio.gov

FRANKLIN COUNTY BENEFITS & WELLNESS OFFICE
373 S. High Street, 25th floor | Columbus, OH 43215
BeWell.franklincountyohio.gov

Franklin County Cooperative Health Improvement Program | ThriveOn Your Health and Wellness Program

UPDATED EFFECTIVE 4/01/25