Spotlight

BENEFITS & WELLNESS NEWSLETTER

2016 Open Enrollment is Mandatory!

Open enrollment begins Monday, February 8th and ends Friday, February 26th.

All eligible employees must enroll or waive coverage.

This is a good opportunity to review your benefits and life insurance information.

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

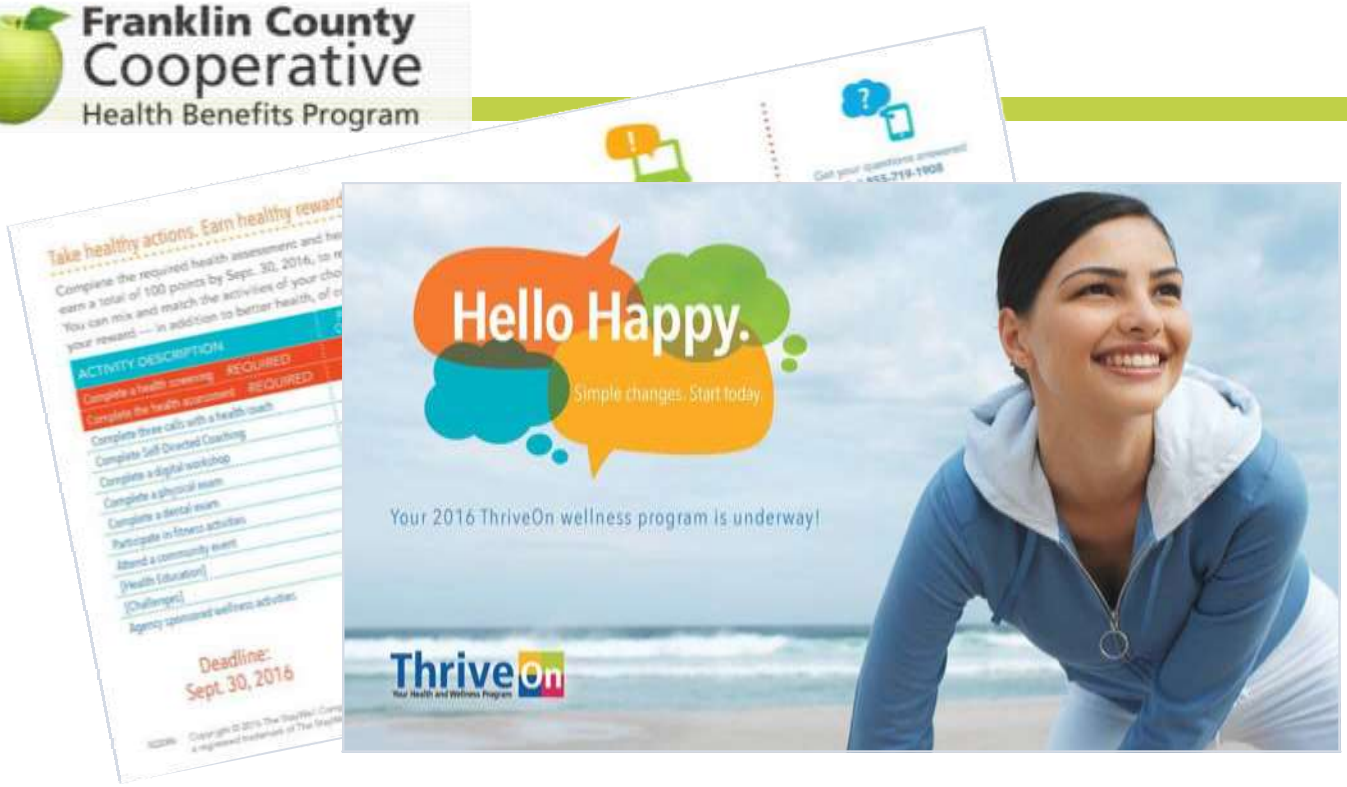
Let's do it together.

Our health plan has experienced a spike in costs over the past 12 months in part from a number of claims exceeding one million dollars and an increase in catastrophic claims over $50,000. When we practice healthy lifestyles and seek out quality care, these costs go down.

Let's work together to make 2016 our year of health. Improve our health and at the same time the health of the plan. Everyone can make a difference.

- Take advantage of your preventive care. Schedule an annual routine wellness exam - which is covered 100% by the plan. If you don't have a family doctor, find one. Use the tools at 'Choosing Wisely' to learn the right questions to ask to improve communication with your doctor.
- Take advantage of the *ThriveOn* programs offered.
- If possible, avoid the Emergency Room and use Urgent Care facilities. Download the Health4Me application from United Healthcare that allows you to easily locate an Urgent Care.
- Check out the new Virtual Visit benefit available in April. Information on this benefit is located in this Newsletter!

Franklin County Cooperative
Health Benefits Program



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

Explore the programs offered through ThriveOn 2016 is going to be very exciting with new programs being offered to help you achieve your personal health goals *AND* earn an incentive. The Health Risk Assessment will be launching again in March 2016. Stay tuned for more information from your Thrive- On program.

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

- Go to http://BeWell.franklincountyohio.gov/ThriveOn
- Log onto https://fccbenefits.com for an FAQ (ThriveOn tab)

READ THIS TO KNOW WHAT TO DO DURING OPEN ENROLLMENT.

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

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

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

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

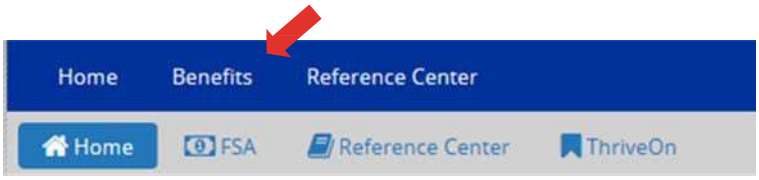
The process is a little different this year. You will be enrolling in a new enrollment system, so you'll need to register a new User Name and Password. The letter that you will receive at home will not include your current benefit elections. You must log onto the new system to review your coverage …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

STEP 1: GO TO HTTPS://FCCBENEFITS.COM

You will need to register a new User Name and Password.
Your company key is **fcc** (all lower case).

STEP 2: REVIEW YOUR CURRENT COVERAGE

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



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

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

QR YOURSELF TO THE SIMPLEST OPEN ENROLLMENT YET!

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

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

Franklin County Cooperative
Health Benefits Program

VIRTUAL VISITS

Access to care - online - 24/7
When you don't feel well, or your child is sick, the last thing you want to do is leave the comfort of home to sit in a waiting room. A virtual visit lets you see and talk to a doctor from your mobile device (phone or tablet) or computer with camera capabilities.

Conditions commonly treated through a virtual visit
Doctors can diagnose and treat a wide range of non-emergency medical conditions, including:

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

No cost to use a virtual visit provider
Your copay for a virtual visit is $0. You have no out-of-pocket cost.

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

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

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

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

VIRTUAL VISIT FAQs

Where can I find out what providers are in the virtual visit net- work and how do I access them? For information about what virtual visit provider groups are in the network, log onto myuhc.com and conduct a provider search. You can also access the provider groups through the UnitedHealthcare's Health4Me app or by going directly to a network virtual visit provider group's mobile app or website.

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

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

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

Not at this time. While you can choose to receive these additional services from a virtual visit provider, the services will not be covered under your virtual visit benefit and you will be responsible for the full cost.

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

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

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

How long is the wait to see a doctor once I am at the provider group's site? Can I schedule an appointment instead of waiting? Virtual visit provider groups are expected to deliver care within 30 minutes or less from the time of a patient's request. You are also able to schedule an appointment with a virtual visit doctor.

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

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

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

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

Can my child or under age de- pendent use virtual visits?

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

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

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

PLAN YEAR CHANGE EFFECTIVE JANUARY 1, 2017

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

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

2017 PLAN YEAR January 1st through December 31st 12 months											
Jan 2017	Feb 2017	Mar 2017	Apr 2017	May 2017	Jun 2017	Jul 2017	Aug 2017	Sep 2017	Oct 2017	Nov 2017	Dec 2017

2016 PLAN YEAR

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

2017 PLAN YEAR

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

SPECIAL ENROLLMENT NOTICE

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in the Cooperative's plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within **30** days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage). In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within **30** days after the marriage, birth, adoption, or placement for adoption. If you do not request enrollment within **30** days, your request to enroll your dependent will be denied.

SUMMARY OF MEDICAL BENEFITS

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

HEALTHY PREGNANCY PROGRAM

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

UnitedHealthcare's HEALTH4ME

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

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

Health4Me

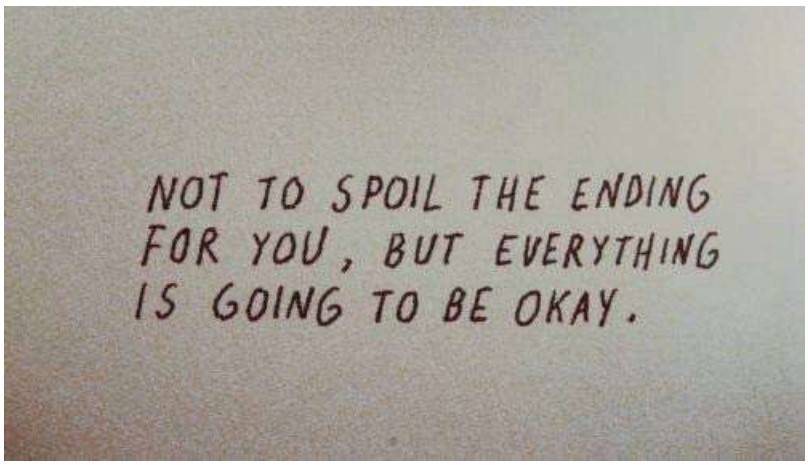
Health4Me's "Easy Connect" feature lets you select the type of questions you have about your claims and benefits, and request a callback on your mobile device from a UnitedHealthcare customer service representative. You can also download your health plan ID card to your smartphone, and email or fax the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

SUMMARY OF BEHAVIORAL HEALTH BENEFITS

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

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

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



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

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

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

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

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

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

SUMMARY OF PRESCRIPTION DRUG BENEFITS

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

FORMULARY CHANGES

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

PRIOR AUTHORIZATION

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

OPTUMRx

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

SUMMARY OF VISION and DENTAL BENEFITS

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

	PPO	
	NETWORK	NON- NETWORK
DENTAL PPO PLAN		
Annual Deductible	None	$25 per person
Coinsurance		
The plan pays:		
- Diagnostic	100%	90%
- Preventive	100%	90%
- Basic	80%	70%
- Major Restorative	80%	60%
Maximum Annual Benefit	$1,500	$1,000
Orthodontia	Children under 19 only	Children Under 19 only
Coinsurance		
The plan pays:	75%	75%
Maximum Lifetime Benefit	$1,500	$1,400

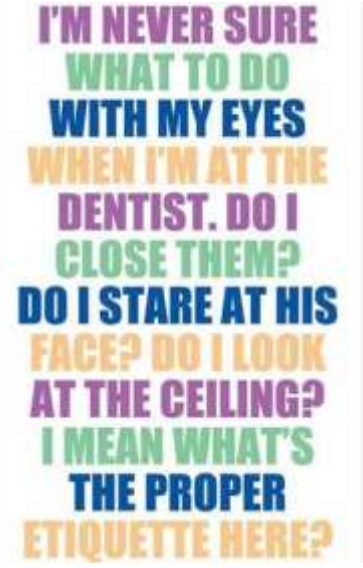
PLAN YEAR RESETS EFFECTIVE APRIL 1st

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

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

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

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



Choosing Wisely®

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

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

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

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

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

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

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

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

Choosing Wisely®
An initiative of the ABIM Foundation

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

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

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

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

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

BASIC LIFE and AD&D INSURANCE

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

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

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

ADDITIONAL LIFE INSURANCE BENEFITS

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

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

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

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

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

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

Fairfield County Majority Basic Life/AD&D: $50,000

SUPPLEMENTAL LIFE INSURANCE

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

- Supplemental Life can be requested up to the following maximum amounts:

Employee:	In $10,000 increments ***up to*** $300,000
Spouse:	In $10,000 increments ***up to*** $150,000
Dependent Children:	In $5,000 increments ***up to*** $10,000

- The Guaranteed Issue amounts are as follows:

Employee:	Up to $100,000
Spouse:	Up to $50,000
Dependent Children:	Up to $10,000

- Supplemental Life is voluntary group term insurance. You pay 100% of the premiums, which are deducted from your paycheck post tax. Premiums are based on your age and the age of spouse on April 1st.
- All life insurance enrollments are made at https://fccbenefits.com.
- Beneficiaries named for Supplemental Life can be different than the beneficiaries named for Basic Life/AD&D.
- If you leave County employment, you can 'take the coverage with you' by porting or converting.
- Evidence of Insurability (EOI) is an application process in which you provide information on the condition of your health in order to be considered for insurance coverage. EOI ***does not*** need to be submitted for Basic Life/AD&D. EOI ***does*** need to be submitted for certain Supplemental Life requests. All EOI requests must be submitted to the life insurance carrier by April 30, 2016.

$10,000 BUMP WITH NO UNDERWRITING

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

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

SUPPLEMENTAL LIFE RATES

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

Supplemental Life Rates
Effective April 1, 2016
Rates for Employee and Spouse

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

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

Rates for Child(ren)

$5,000 increments up to $10,000

GI Amount $10,000	
Amount	**Monthly Cost**
$5,000	$0.65
$10,000	$1.30

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

IRS FORM 1094/1095

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

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

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

How does the IRS know I've had coverage?

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

What does the 1095 form do for me?

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

Form 1095-C provides the following:

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

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

How will I receive my Form 1095-C?

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

What should I do with my 1095-C form?

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

What if I changed employers in 2015?

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

Who can I contact with questions?

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

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

Form **1095-C**
Department of the Treasury
Internal Revenue Service

Employer-Provided Health Insurance Offer and Coverage

► Information about Form 1095-C and its separate instructions is at *www.irs.gov/f1095c.*

☐ VOID
☐ CORRECTED

Part I Employee | **Applicable Large Employer Member (Empl**

1 Name of employee	2 Social security number (SSN)	7 Name of employer	8 E
3 Street address (including apartment no.)		9 Street address (including room or suite no.)	10 C

4 City or town	5 State or province	6 Country and ZIP or foreign postal code	11 City or town	12 State or province	13 C

INFO TO KNOW

W-2 HEALTH CARE COSTS

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

SUMMARY OF BENEFITS AND COVERAGE (SBC)

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

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

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

WOMEN'S HEALTH AND CANCER RIGHTS ACT (WHCRA)

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

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

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

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

COUNTY CONTACT INFORMATION

Fairfield County Human Resources
County Courthouse
210 E. Main Street Rm 106
Lancaster, Ohio 43130

740-652-7893
740-652-7894
740-652-7895

Fax: 740-652-7896

CHECKLIST FOR DEPENDENT ELIGIBILITY

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

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

STEP 1: My child is:

- ❒ A natural, step or adopted (includes placed for adoption) child of mine or my spouse
- ❒ A child for whom legal guardianship has been awarded to me or my spouse
- ❒ A child for whom health care coverage is required through a "Qualified Medical Child Support Order".

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

STEP 2: My child is:

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

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

YOUNG ADULT DEPENDENT COVERAGE

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

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