Commitment             Engagement             Stewardship             Fellowship              Pride

We are the people you know, providing the care you trust. We are devoted to our hospital and are dedicated to our care, our community and each other.

Employee Benefits Guide

2014

We ARE The Difference
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General Enrollment Information

Fairfield Medical Center offers many benefit options to employees. This guide is to summarize our benefit programs and provide required notifications. Your specific rights to benefits under the Plans are governed solely, and in every aspect by the official plan documents and insurance contracts and not by this guide. If there is any discrepancy between the description in this guide and the official plan documents, the language of the official plan documents shall take precedent. Please contact Human Resources with any questions at 740-687-8017.

When can you enroll in benefit plan options?

- New employees have 30 days from their employment date to enroll.
- Employees who experience a life changing event, as defined by federal law, have 30 days from the date of the life changing event to make changes to their benefits.
  - Life changing events may include marriage, divorce, birth/adoption of a child, death of a spouse or child, spouse’s loss of benefit coverage, or loss of coverage through a parent.
- Employees transferring from contingent status to full-time or part-time status have 30 days from the effective date of the transfer to enroll.
- Current employees can enroll or make changes to their benefits each year during the annual benefits open enrollment.

What do you need to enroll? This guide as a reference; name, social security number and date of birth of any dependents you wish to enroll; and beneficiary information (address, phone number, date of birth).

Employee Self-Service (ESS)

Employee Self-Service is a portal of FMC’s Human Resources and Payroll System. All employees are required to have a current direct deposit on file in ESS in order to receive a pay check deposit.

Once you have access to ESS, you will manage your personal and contact information, view current benefits, enroll in benefit plans when eligible, view benefit plan balances and history, update direct deposit information, view or print your pay statements, view pay check deductions and earnings history, and edit tax filing status and withholding allowances.

- You will use your FMC network username and password to access the ESS system.
- If you do not know your network username and password, contact the FMC Help Desk at ext. 8070.
- If you know your username and password and still cannot get in the ESS system, contact Human Resources at 687-8017 to update your username in ESS.


- ESS requires you to have Microsoft Silverlight. If you do not have Silverlight on your home computer, please go to http://www.microsoft.com/silverlight/ to download the most recent version.
- Should you receive an error trying to access ESS from home, please try the following:
  - Set Internet Explorer into Compatibility Mode.
  - Try Alternate web browsers such as Google Chrome or Mozilla Firefox.
  - Try another computer, if possible as a last resort.
**Access Health Network** – The network that includes FMC and providers in Fairfield County. FMC/Access Health Network is the richest level of benefit under the medical health plans (Tier I).

**Benefit Plan Year** – January 1 through December 31 of each year is the period of time when deductibles, out-of-pocket limits and plan limitations are accumulated.

**Contingent Employee** – An employee who is routinely scheduled to work less than 30 hours per pay period and be available to work at irregular times as needed.

**Co-payments** – Fixed dollar amounts (for example $15) you pay for covered health care, usually when you receive the service.

**Co-insurance** – Is your share of the costs of a covered service, calculated as a percent of the allowed amount for the service, after you have paid your deductible.

**Deductible** – The annual amount responsible per covered person prior to benefits being paid.

**Dependent Eligibility** – 1) Legal Spouse; and 2) Dependent Child—a dependent child may be covered with medical, dental and vision up to age 26; or was permanently disabled and covered prior to the attainment of age 26. A dependent child is your: biological child; legally adopted child; stepchild; foster child; or any child for whom you are responsible under a court order. Coverage would terminate at the end of the day in which the dependent child turns 26. Any dependent on active duty in any military force is not eligible for coverage during the period of active duty.

**Emergent/Non-Emergent ER Visit** – An ER claim is determined to be emergent or non-emergent by the ER physician at the time of treatment. The claim is processed according to this code.

**Employee Self-Service (ESS)** - ESS is a portal of FMC’s Human Resources and Payroll System where employees manage many components of their personal, payroll and benefit information, and enroll for benefits when eligible.

**Flexible Spending Account** – Allows an employee to use pre-tax dollars to pay for out-of-pocket employee and/or dependent medical, dental, and vision expenses not reimbursed by insurance. This is a federally granted program.

**Flexible Spending Account Limited Purpose** - Allows an employee to use pre-tax dollars to pay for ONLY dental and vision expenses not reimbursed by insurance. This plan may not be used for medical expenses. It is designed for those participants who are enrolled in a HSA plan. This is a federally granted program.

**Full-time Employee** – An employee who routinely works at least 70 hours per pay period.

**Health Incentive Program (Bravo Wellness)** – Fairfield Medical Center offers a Health Incentive Program to encourage participants to lead healthier lifestyles. The program is free, voluntary, and is only offered to employees and spouses who are enrolled in an FMC health insurance plan. Five health goals are evaluated. You may be able to receive an additional “bonus” point if you have a BMI of ≤27.0. The more points you receive, the lower the percentage of insurance premium you are responsible to pay. Regardless of whether or not you meet any of the goals, you will receive a discount just for participating.
Definition of Terms (continued)

Health Savings Account (HSA) – Allows an employee to use pre-tax dollars to save and pay for out-of-pocket employee and/or dependent medical, dental, and vision expenses not reimbursed by insurance. Can only be used in conjunction with the Consumer Driven Health Plan. This account is opened by the employee at a banking facility of their choice.

Life Changing Qualified Event – An event, as defined by federal law, that allows an employee to change their benefits outside of the annual open enrollment period; i.e. marriage, divorce, birth/adoption of a child, death of a spouse or child, spouse’s loss of benefit coverage, loss of coverage with a parent, or transferring to a benefit status (contingent to full-time or part-time).

MedBen – Third Party Administrator (TPA) for the self-insured health plan offered at Fairfield Medical Center. MedBen pays medical claims based on the plan document and remits medical payments to providers and medical facilities.

Ohio PPO Connect – The network that includes providers and facilities outside of FMC/Access Health. Multiplan is the national network that extends over the United States (Tiers I and II).

Out-of-Pocket Limit – The most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care.

Part-time Employee – An employee who routinely works between 30 and 69 hours per pay period.

Pharmacy Benefit – This defines the pharmacy tiers that exist under the health plan. Prescriptions are based on generic, preferred brand, non-preferred brand and specialty drugs.

Preventive Care/Screening/Immunization – Services that are preventative in nature and coded as such by the provider. Preventive/Wellness Services are covered at 100%, without a co-pay.

Primary Care Referral – All specialty care office visits must have a referral from the primary care physician prior to the specialty visit or the visit will be subject to a 50% penalty (Tier I & Tier II) and such charges are not covered out-of-network. The only exception will be annual wellness visits, which do not require a referral. Referrals will not be processed retrospectively.

Quality Care Partners (QCP) – A medical management company, responsible for referrals and precertification for Fairfield Medical Center (FMC) medical health plans. A reliable access source for benefits utilization and insurance questions.

Urgent Care – All urgent care facilities are covered per the plan guidelines, regardless of the place of service.
Benefit Status vs. Non-Benefit Status

Eligibility: Full-Time/Part-Time

Two benefit status options are available to full-time and part-time employees.

**Benefit Status**
- Accrue Paid Time Off (PTO)
  - Required to take 128 hours time off for full-time and 64 hours time off for part-time
- Benefits are optional to choose

Eligible upon employment for:
- Medical Insurance
- Dental Insurance
- Vision Insurance
- Flexible Spending Account
- Dependent Care
- Group Life Insurance
- Health Savings Account

After 90 Days of Employment, eligible for:
- Employee Pension Contribution
- Short Term Disability
- Tuition Assistance

Additional Options (Unum);
- Supplemental Life
- Supplemental AD&D
- Long Term Disability
- Long Term Care

**Non-Benefit Option**

Full-time and Part-time employees are given the opportunity to choose this option.

- You do not Accrue Paid Time Off (PTO)
  - Still required to take 128 hours time off for full-time and 64 hours time off for part-time (unpaid)
- Not eligible for medical health insurance
- Not eligible for Short Term Disability (STD)

You receive a flat premium based on your actual hours worked.
- The premium is determined by the job family of your position
  - $4.00 professional
  - $3.00 technical
  - $2.00 service/clerical

Eligible upon employment for:
- Dental Insurance
- Vision Insurance
- Flexible Spending Account
- Dependent Care
- Group Life Insurance

After 90 Days of Employment, eligible for:
- Employee Pension Contribution
- Tuition Assistance

Additional Options (Unum);
- Supplemental Life
- Supplemental AD&D
- Long Term Disability
- Long Term Care

NOTE: A newly hired employee may select the Non-Benefit Option within 30 days of their hire date. Any Non-Benefit premium will be effective at the beginning of the current pay period after the election is submitted to Human Resources. Refer to the Non-Benefit policy on the FMC Intranet for more information.

> Time off for bereavement and jury duty is unpaid.
401(k) Pension Plan

Eligibility: Full-Time/Part-Time/Non-Benefit/Contingent
Upon Employment
Employee contribution election begins after 90 days of employment

Contact Info: Fairfield National Bank
740-681-8246
www.retirementlogin.com/save2retire

FMC 401(k) Pension Plan
FMC is unique in the fact it is an employer paid pension plan. We are contributing funds to your pension plan whether you put money in or not.

- If you are 21 years of age or older, you are automatically enrolled in the FMC 401(k) pension plan at 1% deduction from your paycheck. You may change your contribution election at anytime throughout the year.
- Once you have been employed at FMC for one year, worked 1,000 hours in the calendar year, and 21 years of age and older, FMC will put 5% of your gross income into your pension and match up to 2% of your employee contribution (whether you elect a dollar amount or a percentage amount).
- Your annual contribution is limited by the IRS to $17,500 per year – This only includes your contribution (not FMC’s contribution). If you are age 50 or older, you may contribute an additional $5,500 per year.
- The vestment period for the FMC contribution to be your money at 100% is three years. You must meet the following criteria to be considered a vested year: One year of service; worked 1,000 hours (January 1-December 31); and 21 years of age or older.
- The plan does accept pre-tax rollover money from other qualified accounts.
- Fairfield National Bank is the trustee of FMC’s pension plan.

403(b) Retirement Plan

Eligibility: Full-Time/Part-Time/Non-Benefit/Contingent
Upon Employment

Contact Info: Aspire (www.aspirefinserv.com) (current 403(b) pension statements)
APS/Pentegra
614-501-7790 (questions about advisors, mutual fund options, fees, etc.)

An additional 403(b) retirement plan is available to you. To establish a 403(b) account, you must complete a paper application that is available in Human Resources. A list of companies who currently offer tax sheltered annuities (TSA) to FMC employees is listed on the next page of this guide. If you are currently established with a 403(b) account, you may change your deduction amount throughout the year. 403(b) accounts are processed through Aspire, www.aspirefinserv.com; however any questions about advisors, mutual options, fees, etc. can be directed to APS/Pentegra at 614-501-7790.
Fairfield Medical Center 403(b) Financial Advisors

Wells Fargo Advisors
John Acton, JD
Financial Advisor
Wells Fargo Advisors, LLC
128 North Broad Street
Lancaster, Ohio 43130
(740) 653-9730
Fax (740) 653-9759
Toll Free (888) 406-8252
john.acton@wfadvisors.com
(Completed Rep. Form)

Valic Advisor
Neal Bechant
Financial Advisor
Central Region
8050 North High Street, Suite 130
Columbus, Ohio 43235
800-892-5558 Ext. 88899
614-403-0432 Cellular
neal.bechant@valic.com

Raymond James
Allison Spangler
Raymond James @ Fairfield National Bank
Financial Advisor, RJFS
143 West Main Street
Post office Box 607
Lancaster, Ohio 43130-0607
(740) 681-8245
Fax (740) 653-8004
allison.spangler@raymondjames.com
www.fairfieldnationalbank.com
(Completed Rep. Form)

Edward Jones
Joe Barrows
130 W. Chestnut Street
PO Box 577
Lancaster, Ohio 43130
740-653-6987
Fax (888)213-4922
Joe.barrows@edwardjones.com
(Completed Rep. Form)
John J. Kelley, Jr.
600 North Broad Street
Lancaster, Ohio 43130
(740) 653-5302
Fax (888) 369-2202
John.kelley@edwardjones.com
(Completed Rep. Form)

Edward Jones (con’t)
Christopher C. Welsh
113 West Market Street
Baltimore, Ohio 43105
(740) 862-6362
Fax (877) 730-6218
chris.welsh@edwardjones.com
www.edwardjones.com
(Completed Rep. Form)

Stifel, Nicolaus & Company, Incorporated
Stephen F. Messerly, CRPC
Vice President/Investments
109 East Main Street, Suite 308
Lancaster, Ohio 43130
(740) 653-5996
Fax (740) 654-5230
Toll Free (888) 632-0028
MESSERLYS@STIFEL.COM
(Completed Rep. Form)

Stifel, Nicolaus & Company, Inc. (con’t)
Jamie Culver
109 East Main Street, Suite 308
Lancaster, Ohio 43130
(740) 654-5996
culveri@stifel.com
(Completed Rep. Form)

Kathy Kittredge
Century Securities Association, Inc.
(Subsidiary of Stifel Financial)
109 East Main Street, Suite 323
Lancaster, Ohio 43130
(740) 653-9222
Fax (740) 652-9280
Cell (740) 215-9219
kittredgek@centurysecurities.com
(Completed Rep. Form)

JC Wealth Management Group
Stephen A. Rogers, Financial Advisor
125 West Mulberry Street
Lancaster, Ohio 43130
(740) 653-9581
Fax (740) 653-0983
SRogers@JCCCPA.com
(Completed Rep. Form)

Dean A. Cochenour, Financial Advisor
125 West Mulberry Street
Lancaster, Ohio 43130
(740) 653-9581
Fax (740) 653-0983
DCochenour@JCCCPA.com
(Completed Rep. Form)
Employee Health Plans

Eligibility:  
Full-Time/Part-Time  
Upon Employment  
Must enroll within 30 days of employment or eligibility

Contact Info:  
MedBen  
1-800-686-8425  
www.medben.com

You may enroll in an employee health plan within the first 30 days of employment, within 30 days of a qualified life changing event, or during an annual open enrollment period. Fairfield Medical Center’s health plan is managed through MedBen, to assist you and your family with the cost of health care.

Full-time employees who participate in a medical health plan are responsible for a fraction of the monthly premium and Fairfield Medical Center pays the balance. Part-time employees who participate in a medical health plan are responsible for a larger fraction than full-time employees. The employee portion of the medical health premium is made through payroll deduction.

Two employee health plans are offered – Coordinated Care Health Plan (COOR) and Consumer Driven Health Plan (CDHP). If you elect an employee health plan, you have the option to participate in the Health Incentive Program to receive a discount on your insurance premium.
Health Incentive Program
The more points you receive, the lower the percentage of insurance premium you are responsible to pay.

Eligibility: Full-time/Part-time Employee and/or Spouse

Must be enrolled in an FMC employee health plan
Eligible employees will have the opportunity to register in June

Contact Info: Bravo Wellness
1-877-662-7286

Health & Wellness Services
740-687-6822

Fairfield Medical Center cares about you and your family, and as part of the benefits program, offers a Health Incentive Program to encourage participants to lead healthier lifestyles. The program is free, voluntary, and is only offered to you and/or your spouse, if enrolled in an FMC health plan. For each health goal that is reached, you and/or your spouse receive one point, for a total of five points each. The more points you receive, the lower your insurance premium will be! Regardless of whether or not you meet any of the goals, you will receive a discount just for participating.

The five health goals for 2015 are:

- Body Mass Index < 28.5 or 10% reduction in weight from the most previous health incentive program screening
- Blood Pressure < 125/80
- LDL Cholesterol < 130
- A1c (glucose) < 6.5%
- Tobacco/Nicotine – Negative

As a new employee or new-to-benefits employee, you will not be eligible to participate in this program until registration opens in June. Your premium will automatically be defaulted to the “4” or “9” point level. Your health insurance premium will depend on your current employment status, full-time or part-time, and which plan you select, Coordinated Care Health Plan or Consumer Driven Health Plan (please see the charts on the next page for premium prices).

If you choose to participate in the program, you will need to register in June of each year. Information regarding the registration timeframe will be provided in Fairfield Medical Center’s Monday Morning and FMC email. If you do not register in June, you will be unable to participate in the program and will pay premiums based on a “non-participant” status.

- Registration information will be completed in June of each year. The program is online. You will need to complete the “Know Your Numbers” questionnaire and then you will have the option to select from several health screening opportunities in July or August. Please note, if you fail to screen you will be ineligible to participate in the health incentive program and will pay a premium based on the “non-participant” status.
- Previously drawn lab results may NOT be used for the health screening.
- If, after receiving your results, and you believe they are incorrect or it is unreasonably difficult to meet FMC’s established goals due to a medical condition or it is medically inadvisable, you may appeal your results. The deadline to appeal is 45 days from the date on your Bravo Report.

Failure to complete the registration and wellness screening will make you ineligible for this voluntary program.

This program is confidential, and FMC does not receive any individualized information. All of your personal health information is stored by Bravo Wellness, a company who manages the health questionnaire and results of your testing. The screenings are performed by Superior Mobile Screening Company.
FAIRFIELD MEDICAL CENTER
2014 Employee Health Plans
Full-time Status

Premiums Listed Below are Per Pay

Health insurance premiums are based on points from your Health Incentive Screening. Employees new to the plan: 4 points are given for Single coverage; and 9 points for Employee + Child; Employee + Spouse or Family coverage. Once your Health Incentive Screening points are reported by Bravo, your premium is adjusted based on your points earned. If you do not participate in the program, your points will be adjusted to the non-participant premium.

Full-time Premiums

**COORDINATED CARE HEALTH PLAN (COOR)**

<table>
<thead>
<tr>
<th>Total Points Earned</th>
<th>Employee</th>
<th>Total Points Earned</th>
<th>Employee + Child</th>
<th>Employee + Spouse</th>
<th>Family</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non-Participant</td>
<td>$120.67</td>
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<td>$276.45</td>
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<td>0 Points</td>
<td>$ 87.76</td>
<td>0-1 Points</td>
<td>$201.06</td>
<td>$211.12</td>
<td>$234.11</td>
</tr>
<tr>
<td>1 Point</td>
<td>$ 87.76</td>
<td>2-3 Points</td>
<td>$201.06</td>
<td>$211.12</td>
<td>$234.11</td>
</tr>
<tr>
<td>2 Points</td>
<td>$ 76.79</td>
<td>4-5 Points</td>
<td>$175.92</td>
<td>$184.73</td>
<td>$204.85</td>
</tr>
<tr>
<td>3 Points</td>
<td>$ 65.82</td>
<td>6-7 Points</td>
<td>$150.79</td>
<td>$158.34</td>
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<tr>
<td>4 Points</td>
<td>$ 54.85</td>
<td>8-9 Points</td>
<td>$125.66</td>
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<td>5 Points</td>
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<td>6 Points</td>
<td>$ 41.47</td>
<td>12 Points</td>
<td>$ 95.00</td>
<td>$ 99.75</td>
<td>$110.62</td>
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**CONSUMER DRIVEN HEALTH PLAN (CDHP)**

<table>
<thead>
<tr>
<th>Total Points Earned</th>
<th>Employee</th>
<th>Total Points Earned</th>
<th>Employee + Child</th>
<th>Employee + Spouse</th>
<th>Family</th>
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<tbody>
<tr>
<td>Non-Participant</td>
<td>$ 41.03</td>
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<td>$ 98.68</td>
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<td>0 Points</td>
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<td>1 Point</td>
<td>$ 29.84</td>
<td>2-3 Points</td>
<td>$ 59.78</td>
<td>$ 62.77</td>
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<tr>
<td>2 Points</td>
<td>$ 26.11</td>
<td>4-5 Points</td>
<td>$ 52.30</td>
<td>$ 54.92</td>
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<td>3 Points</td>
<td>$ 22.38</td>
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<td>$ 44.83</td>
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<td>4 Points</td>
<td>$ 18.65</td>
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<tr>
<td>6 Points</td>
<td>$ 14.10</td>
<td>12 Points</td>
<td>$ 27.92</td>
<td>$ 29.32</td>
<td>$ 39.20</td>
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</table>
FAIRFIELD MEDICAL CENTER
2014 Employee Health Plans
Part-time Status

Premiums Listed Below are Per Pay
Health insurance premiums are based on points from your Health Incentive Screening. Employees new to the plan: 4 points are given for Single; and 9 points for Employee + Child; Employee + Spouse or Family coverage. Once your Health Incentive Screening points are reported by Bravo, your premium is adjusted based on your points earned. If you do not participate in the program, your points will be adjusted to the non-participant premium.

### Part-time Premiums

#### COORDINATED CARE HEALTH PLAN (COOR)

<table>
<thead>
<tr>
<th>Total Points Earned</th>
<th>Employee</th>
<th>Total Points Earned</th>
<th>Employee + Child</th>
<th>Employee + Spouse</th>
<th>Family</th>
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<tr>
<td>1 Point</td>
<td>$175.52</td>
<td>2-3 Points</td>
<td>$402.11</td>
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</tr>
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<td>2 Points</td>
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<td>4-5 Points</td>
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<td>5 Points</td>
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<td>10-11 Points</td>
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<td>6 Points</td>
<td>$ 82.93</td>
<td>12 Points</td>
<td>$190.00</td>
<td>$199.51</td>
<td>$221.24</td>
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#### CONSUMER DRIVEN HEALTH PLAN (CDHP)

<table>
<thead>
<tr>
<th>Total Points Earned</th>
<th>Employee</th>
<th>Total Points Earned</th>
<th>Employee + Child</th>
<th>Employee + Spouse</th>
<th>Family</th>
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</thead>
<tbody>
<tr>
<td>Non-Participant</td>
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<td>Non-Participant</td>
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<tr>
<td>0 Points</td>
<td>$59.68</td>
<td>0-1 Points</td>
<td>$119.55</td>
<td>$125.54</td>
<td>$165.92</td>
</tr>
<tr>
<td>1 Point</td>
<td>$59.68</td>
<td>2-3 Points</td>
<td>$119.55</td>
<td>$125.54</td>
<td>$165.92</td>
</tr>
<tr>
<td>2 Points</td>
<td>$52.22</td>
<td>4-5 Points</td>
<td>$104.61</td>
<td>$109.84</td>
<td>$145.18</td>
</tr>
<tr>
<td>3 Points</td>
<td>$44.76</td>
<td>6-7 Points</td>
<td>$ 89.66</td>
<td>$ 94.15</td>
<td>$124.44</td>
</tr>
<tr>
<td>4 Points</td>
<td>$37.30</td>
<td>8-9 Points</td>
<td>$ 74.72</td>
<td>$ 78.46</td>
<td>$103.70</td>
</tr>
<tr>
<td>5 Points</td>
<td>$29.84</td>
<td>10-11 Points</td>
<td>$ 59.78</td>
<td>$ 62.77</td>
<td>$ 82.96</td>
</tr>
<tr>
<td>6 Points</td>
<td>$28.20</td>
<td>12 Points</td>
<td>$ 56.49</td>
<td>$ 59.32</td>
<td>$ 78.40</td>
</tr>
</tbody>
</table>
**Fairfield Medical Center Employee Health Plan-COOR**  
Coverage Period: 01/01/2014 through 12/31/2014

**Summary of Benefits and Coverage: What this Plan Covers & What it Costs**

Coverage for: Individual & Family | Plan Type: PPO

---

**Important Questions**

<table>
<thead>
<tr>
<th>Important Questions</th>
<th>Answers</th>
<th>Why this Matters</th>
</tr>
</thead>
<tbody>
<tr>
<td>What is the overall deductible?</td>
<td>$400 per individual, per calendar year for all tiers. <strong>Deductible</strong> not applied to wellness services, items listed as no charge, in-network with a <strong>co-payment</strong> (except ER in non-emergency) listed as no charge, hospice, prescription drugs through Rx program &amp; urgent care facilities.</td>
<td>You must pay all the costs up to the <strong>deductible</strong> amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the <strong>deductible</strong> starts over (Usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the <strong>deductible</strong>.</td>
</tr>
<tr>
<td>Are there other deductibles for specific services?</td>
<td>Yes. $100 per calendar year for drugs through Rx program.</td>
<td>You must pay all of the costs for these services up to the specific <strong>deductible</strong> amount before this plan begins to pay for these services.</td>
</tr>
<tr>
<td>Is there an out-of-pocket limit on my expenses?</td>
<td>Yes. $2,000 per individual for Tier I and Tier II; $4,000 per individual for Tier III, per calendar year.</td>
<td>The <strong>out-of-pocket limit</strong> is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.</td>
</tr>
<tr>
<td>What is not included in the out-of-pocket limit?</td>
<td>Premiums, balance-billed charges, charges this plan doesn’t cover, <strong>co-payments</strong>, prescription drugs through Rx programs, reduced <strong>co-insurance</strong> for failure to get a referral, and precertification penalties.</td>
<td>Even though you pay these expenses, they don’t count toward the <strong>out-of-pocket limit</strong>.</td>
</tr>
<tr>
<td>Is there an overall annual limit on what the plan pays?</td>
<td>No.</td>
<td>The chart starting on page 2 describes any limits on what the plan will pay for specific covered services, such as office visits.</td>
</tr>
<tr>
<td>Does this plan use a network of providers?</td>
<td>Yes. For a list of <strong>preferred providers</strong>, see fmchealth.org/index.php?option=com_wrapper&amp;view=wrapper&amp;Itemid=63 (Access Health), ohioppoconnect.com (Ohio PPO Connect), <a href="http://www.multiplan.com">www.multiplan.com</a> (Multiplan for out-of-area), or call 866-245-9374.</td>
<td>If you use an in-network doctor or other health care <strong>provider</strong>, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network <strong>provider</strong> for some services. Plans use the term in-network, <strong>preferred</strong>, or participating for <strong>providers</strong> in their <strong>network</strong>. See the chart starting on page 2 for how this plan pays different kinds of <strong>providers</strong>.</td>
</tr>
<tr>
<td>Do I need a referral to see a specialist?</td>
<td>Yes, or 50% <strong>co-insurance</strong> applies to in-office services at the in-network (Tier I &amp; Tier II) level and such charges are not covered out-of-network.</td>
<td>This plan will pay some or all of the costs to see a <strong>specialist</strong> for covered services but only if you have the plan’s permission before you see the <strong>specialist</strong>.</td>
</tr>
<tr>
<td>Are there services this plan doesn’t cover?</td>
<td>Yes.</td>
<td>Some of the services this plan doesn’t cover are listed on page 4. See your policy or plan document for additional information about excluded services.</td>
</tr>
</tbody>
</table>

---

**Questions:** Call 1-800-686-8425 or visit us at www.medben.com.

If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at ccio.cms.gov/resources/other/index.html#sbwcg or call 1-800-686-8425 to request a copy.
Fairfield Medical Center Employee Health Plan-COOR Coverage Period: 01/01/2014 through 12/31/2014
Coverage for: Individual & Family | Plan Type: PPO

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is your share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's allowed amount for an overnight hospital stay is $1,000, your coinsurance payment of 20% would be $200. This may change if you haven’t met your deductible.
- The amount the plan pays for covered services is based on the allowed amount. If an out-of-network provider charges more than the allowed amount, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the allowed amount is $1,000, you may have to pay the $500 difference. (This is called balance billing)
- This plan may encourage you to use Access Health, Ohio PPO Connect or Multiplan (if out-of-area providers by charging you lower deductibles, copayments and coinsurance amounts.

### Common Medical Event

<table>
<thead>
<tr>
<th>Services You May Need</th>
<th>Your cost if you use an</th>
<th>Limitations &amp; Exceptions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary care visit to treat an injury or illness</td>
<td>Tier I - Access Health Provider</td>
<td>Tier II - Other in-network Provider Tier III - Out-of-network Provider</td>
</tr>
<tr>
<td></td>
<td>$10 co-payment, per visit</td>
<td>$10 co-payment, per visit $25 co-payment, per visit</td>
</tr>
<tr>
<td></td>
<td></td>
<td>$40% coinsurance per visit</td>
</tr>
<tr>
<td>Specialist visit</td>
<td>$25 co-payment, per visit</td>
<td>$25 co-payment, per visit $50 co-payment, per visit</td>
</tr>
<tr>
<td>Other practitioner office visit</td>
<td>20% coinsurance</td>
<td>20% coinsurance          40% coinsurance</td>
</tr>
<tr>
<td>Preventive care/screening/immunization</td>
<td>No charge</td>
<td>No charge               40% coinsurance, no deductible</td>
</tr>
<tr>
<td>Diagnostic test (x-ray, blood work)</td>
<td>No charge after deductible</td>
<td>20% coinsurance          40% coinsurance</td>
</tr>
</tbody>
</table>

Questions: Call 1-800-686-8425 or visit us at www.medben.com.
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<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>Your cost if you use an</th>
<th>Limitations &amp; Exceptions</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Tier I - Access Health Provider</td>
<td>Tier II - Other in-network Provider</td>
</tr>
<tr>
<td>Imaging (CT/PET scans, MRIs)</td>
<td>No charge after deductible</td>
<td>Not covered</td>
<td>Not covered</td>
</tr>
<tr>
<td>If you need drugs to treat your illness or condition</td>
<td>Generic drugs</td>
<td>Not covered</td>
<td>$100 Rx deductible, then 25% co-insurance</td>
</tr>
<tr>
<td></td>
<td>Preferred brand drugs</td>
<td>Not covered</td>
<td>$100 Rx deductible, then 40% co-insurance</td>
</tr>
<tr>
<td></td>
<td>Non-preferred brand drugs</td>
<td>Not covered</td>
<td>$100 Rx deductible, then 50% co-insurance</td>
</tr>
<tr>
<td></td>
<td>Specialty drugs</td>
<td>Not covered</td>
<td>Same as above</td>
</tr>
<tr>
<td>If you have outpatient surgery</td>
<td>Facility fee (e.g., ambulatory surgery center)</td>
<td>No charge after deductible</td>
<td>20% co-insurance</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>No charge after deductible</td>
<td>20% co-insurance</td>
</tr>
<tr>
<td>If you need immediate medical attention</td>
<td>Emergency room services</td>
<td>$75 co-payment</td>
<td>$75 co-payment</td>
</tr>
<tr>
<td></td>
<td>Emergency medical transportation</td>
<td>No charge after deductible</td>
<td>No charge after deductible</td>
</tr>
<tr>
<td></td>
<td>Urgent care</td>
<td>$35 co-payment</td>
<td>$35 co-payment</td>
</tr>
</tbody>
</table>

Questions: Call 1-800-686-8425 or visit us at www.medben.com.
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## Fairfield Medical Center Employee Health Plan-COOR

**Coverage Period:** 01/01/2014 through 12/31/2014

**Summary of Benefits and Coverage:** What this Plan Covers & What it Costs

**Coverage for:** Individual & Family  |  **Plan Type:** PPO

<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>Your cost if you use an</th>
<th>Limitations &amp; Exceptions</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Tier I - Access (Health) Provider</td>
<td>Tier II - Other in-network Provider</td>
</tr>
<tr>
<td>If you have a hospital stay</td>
<td>Facility fee (e.g., hospital room)</td>
<td>No charge after deductible</td>
<td>$200 co-payment, deductible then 20% co-insurance</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fee</td>
<td>No charge after deductible</td>
<td>20% co-insurance</td>
</tr>
<tr>
<td>If you have mental health, behavioral health, or substance abuse needs</td>
<td>Mental/Behavioral health outpatient services</td>
<td>Paid same as other conditions, except as noted</td>
<td>Paid same as other conditions, except as noted</td>
</tr>
<tr>
<td></td>
<td>Mental/Behavioral health inpatient services</td>
<td>Paid same as other conditions</td>
<td>Paid same as other conditions</td>
</tr>
<tr>
<td></td>
<td>Substance use disorder outpatient services</td>
<td>Paid same as other conditions, except as noted</td>
<td>Paid same as other conditions, except as noted</td>
</tr>
<tr>
<td></td>
<td>Substance use disorder inpatient services</td>
<td>Paid same as other conditions</td>
<td>Paid same as other conditions</td>
</tr>
<tr>
<td>If you are pregnant</td>
<td>Prenatal and postnatal care</td>
<td>Paid same as other conditions</td>
<td>Paid same as other conditions</td>
</tr>
<tr>
<td></td>
<td>Delivery and all inpatient services</td>
<td>Paid same as other conditions</td>
<td>Paid same as other conditions</td>
</tr>
<tr>
<td>If you need help recovering or have other special health needs</td>
<td>Home health care</td>
<td>Not applicable</td>
<td>20% co-insurance</td>
</tr>
<tr>
<td></td>
<td>Rehabilitation services</td>
<td>No charge after deductible</td>
<td>20% co-insurance</td>
</tr>
</tbody>
</table>

Questions: Call 1-800-686-8425 or visit us at www.medben.com. If you aren’t clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at ccio.cms.gov/resources/other/index.html#sbcng or call 1-800-686-8425 to request a copy.
### Fairfield Medical Center Employee Health Plan-COOR

**Coverage Period:** 01/01/2014 through 12/31/2014

**Summary of Benefits and Coverage:** What this Plan Covers & What it Costs

**Coverage for:** Individual & Family | **Plan Type:** PPO

<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>Your cost if you use an</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Tier I - Access (Health) Provider</td>
</tr>
<tr>
<td>Habilitation services</td>
<td></td>
<td>No charge after deductible</td>
</tr>
<tr>
<td>Skilled nursing care</td>
<td></td>
<td>No charge after deductible</td>
</tr>
<tr>
<td>Durable medical equipment</td>
<td></td>
<td>No charge after deductible</td>
</tr>
<tr>
<td>Hospice service</td>
<td></td>
<td>No charge</td>
</tr>
</tbody>
</table>

**If your child needs dental or eye care**

<table>
<thead>
<tr>
<th></th>
<th></th>
<th>Tier I - Access (Health) Provider</th>
<th>Tier II - Other in-network Provider</th>
<th>Tier III - Out-of-network Provider</th>
<th>Limitations &amp; Exceptions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eye exam</td>
<td>Not covered, except as noted</td>
<td></td>
<td>Not covered</td>
<td>Not covered</td>
<td>Recommended wellness exams are no charge at Tier I &amp; II. None.</td>
</tr>
<tr>
<td>Glasses</td>
<td>Not covered</td>
<td></td>
<td>Not covered</td>
<td>Not covered</td>
<td>None.</td>
</tr>
<tr>
<td>Dental check-up</td>
<td>Not covered</td>
<td></td>
<td>Not covered</td>
<td>Not covered</td>
<td>None.</td>
</tr>
</tbody>
</table>

### Excluded Services & Other Covered Services:

- Acupuncture,
- Benefits paid as a result of injuries caused by another party may need to be repaid to the health plan or paid for by another party under certain circumstances,
- Cosmetic surgery, except following injury, to restore function for congenital defect of child or breast reconstruction following mastectomy,
- Dental care (Adult and child), except injury to teeth started within 31 days & completed within 6 months, removal of full & partial boney impactions, gingivectomy & alveolectomy,
- Hearing aids, including cochlear implants, and exams for prescription and fitting of hearing aids,
- Infertility treatment, including work-up,
- Long-term care,
- Private duty nursing, except as covered through home health,
- Routine eye care (Adult and child),
- Routine foot care, and
- Weight loss programs.

### Questions:

Call 1-800-686-8425 or visit us at www.medben.com.

If you aren’t clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at ccio.cms.gov/resources/other/index.html#sbcug or call 1-800-686-8425 to request a copy.
Other Covered Services (This isn’t a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Chiropractic care, limited to manipulations & routine x-rays of neck/spine (unless approved), and to 20 visits per calendar year,
- Bariatric surgery for morbid obesity, limited to $20,000 per lifetime, and
- Non-emergency care when traveling outside the U.S., unless purpose of travel was to obtain treatment.

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending on the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a premium, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may apply.

For more information on your rights to continue coverage, contact the plan in care of MedBen’s Customer Service Department at 1-800-686-8425. You may also contact your state insurance department or the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to appeal or file a grievance. For questions about your rights, this notice, or assistance, you can contact: MedBen’s Customer Service Department at 1-800-686-8425, or e-mail MedBen at www.medben.com or the U.S. Department of Labor’s Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. Additionally, a consumer assistance program may be available in your state to help you file your appeal. A list of states with Consumer Assistance Programs is available at www.healthcare.gov/using-insurance/managing/consumer-help/index.html.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as “minimum essential coverage.” This plan or policy does provide minimum essential coverage.

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). This health coverage does meet the minimum value standard for the benefits it provides.

Language Access Services:

Para obtener asistencia en Español, llame al 1-800-862-6704.

——To see examples of how this plan might cover costs for a sample medical situation, see the next page.——

Questions: Call 1-800-686-8425 or visit us at www.medben.com.
If you aren’t clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at ccio.cms.gov/resources/other/index.html#sbcwg or call 1-800-686-8425 to request a copy.
About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

### Having a baby (normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays:** $6,740
- **Patient pays:** $800

#### Sample care costs:

<table>
<thead>
<tr>
<th>Service</th>
<th>Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital charges (mother)</td>
<td>$2,700</td>
</tr>
<tr>
<td>Routine obstetric care</td>
<td>$2,100</td>
</tr>
<tr>
<td>Hospital charges (baby)</td>
<td>$900</td>
</tr>
<tr>
<td>Anesthesia</td>
<td>$900</td>
</tr>
<tr>
<td>Laboratory tests</td>
<td>$500</td>
</tr>
<tr>
<td>Prescriptions</td>
<td>$200</td>
</tr>
<tr>
<td>Radiology</td>
<td>$200</td>
</tr>
<tr>
<td>Vaccines, other preventive</td>
<td>$40</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>$7,540</strong></td>
</tr>
</tbody>
</table>

- **Patient pays:**
  - **Deductibles:** $400
  - **Co-pays:** $0
  - **Co-insurance:** $0
  - **Limits or exclusions:** $400
  - **Total:** $800

### Managing type 2 diabetes (routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays:** $3,510
- **Patient pays:** $1,890

#### Sample care costs:

<table>
<thead>
<tr>
<th>Service</th>
<th>Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prescriptions</td>
<td>$2,900</td>
</tr>
<tr>
<td>Medical Equipment and Supplies</td>
<td>$1,300</td>
</tr>
<tr>
<td>Office Visits and Procedures</td>
<td>$700</td>
</tr>
<tr>
<td>Education</td>
<td>$300</td>
</tr>
<tr>
<td>Laboratory tests</td>
<td>$100</td>
</tr>
<tr>
<td>Vaccines, other preventive</td>
<td>$100</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>$5,400</strong></td>
</tr>
</tbody>
</table>

- **Patient pays:**
  - **Deductibles:** $100
  - **Co-pays:** $90
  - **Co-insurance:** $1,400
  - **Limits or exclusions:** $200
  - **Total:** $1,790

---

Questions: Call 1-800-686-8425 or visit us at www.medben.com.

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Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don’t include premiums.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren’t specific to a particular geographic area or health plan.
- The patient’s condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network providers. If the patient had received care from out-of-network providers, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how deductibles, copayments, and coinsurance can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn’t covered or payment is limited.

Does the Coverage Example predict my own care needs?

**No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor’s advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

**No.** Coverage Examples are not cost estimators. You can’t use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your providers charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

**Yes.** When you look at the Summary of Benefits and Coverage for other plans, you’ll find the same Coverage Examples. When you compare plans, check the “Patient Pays” box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

**Yes.** An important cost is the premium you pay. Generally, the lower your premium, the more you’ll pay in out-of-pocket costs, such as copayments, deductibles, and coinsurance. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

Questions: Call 1-800-686-8425 or visit us at www.medben.com.

If you aren’t clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at www.dol.gov/ebsa/healthreform or call 1-800-686-8425 to request a copy.
## Fairfield Medical Center Employee Health Plan-CDHP

**Coverage Period:** 01/01/2014 through 12/31/2014

**Summary of Benefits and Coverage:** What this Plan Covers & What it Costs

**Coverage for:** Individual & Family | **Plan Type:** PPO/HDHP

---

### Important Questions

<table>
<thead>
<tr>
<th>Important Questions</th>
<th>Answers</th>
<th>Why this Matters:</th>
</tr>
</thead>
<tbody>
<tr>
<td>What is the overall deductible?</td>
<td>$2,500 per individual &amp; $5,000 per family, per calendar year. <strong>Deductible</strong> not applied to wellness services.</td>
<td>You must pay all the costs up to the <strong>deductible</strong> amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the <strong>deductible</strong> starts over. (Usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the <strong>deductible</strong>.</td>
</tr>
<tr>
<td>Are there other deductible costs for specific services?</td>
<td>No. <strong>Deductible</strong> only for Tier I; $4,000 per individual and $8,000 per family for Tier II; $9,000 per individual and $11,000 per family for Tier III, per calendar year.</td>
<td>You don’t have to meet <strong>deductible</strong> for specific services, but see the chart starting on page 2 for other costs for services this plan covers.</td>
</tr>
<tr>
<td>Is there an out-of-pocket limit on my expenses?</td>
<td>Yes. <strong>Deductible</strong> only for Tier I; $4,000 per individual and $8,000 per family for Tier II; $9,000 per individual and $11,000 per family for Tier III, per calendar year.</td>
<td>The <strong>out-of-pocket limit</strong> is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.</td>
</tr>
<tr>
<td>What is not included in the out-of-pocket limit?</td>
<td>Premiums, balance-billed charges, charges this plan doesn’t cover, co-payments, penalties for failure to get a referral, and pre-certification penalties.</td>
<td>Even though you pay these expenses, they don’t count toward the <strong>out-of-pocket limit</strong>.</td>
</tr>
<tr>
<td>Is there an overall annual limit on what the plan pays?</td>
<td>No.</td>
<td>The chart starting on page 2 describes any limits on what the plan will pay for specific covered services, such as office visits.</td>
</tr>
<tr>
<td>Does this plan use a network of providers?</td>
<td>Yes. For a list of <strong>preferred providers</strong>, see <a href="https://fmhealth.org/index.php?option=com_wrapper&amp;view=wrapper&amp;Itemid=63">fmhealth.org/index.php?option=com_wrapper&amp;view=wrapper&amp;Itemid=63</a> (Access Health), see <a href="http://ohioconnect.com">ohioconnect.com</a> (Ohio PPO Connect), <a href="http://www.multiplan.com">www.multiplan.com</a> (Multiplan for out-of-area), or call 866-245-9374.</td>
<td>If you use an in-network doctor or other health care <strong>provider</strong>, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network <strong>provider</strong> for some services. Plans use the term in-network, <strong>preferred</strong>, or participating for <strong>providers</strong> in their <strong>network</strong>. See the chart starting on page 2 for how this plan pays different kinds of <strong>providers</strong>.</td>
</tr>
<tr>
<td>Do I need a referral to see a specialist?</td>
<td>Yes, or covered expenses for in-office services at the in-network (Tier I &amp; Tier II) level will be reduced by 50% and such charges are not covered out-of-network.</td>
<td>This plan will pay some of all the costs to see a <strong>specialist</strong> for covered services but only if you have the plan’s permission before you see the <strong>specialist</strong>.</td>
</tr>
<tr>
<td>Are there services this plan doesn’t cover?</td>
<td>Yes.</td>
<td>Some of the services this plan doesn’t cover are listed on page 4. See your policy or plan document for additional information about <strong>excluded services</strong>.</td>
</tr>
</tbody>
</table>

### Questions:

Call 1-800-686-8425 or visit us at www.medben.com. If you aren’t clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at [ccio.cms.gov/resources/other/index.html#sbccug](http://ccio.cms.gov/resources/other/index.html#sbccug) or call 1-800-686-8425 to request a copy.
**Fairfield Medical Center Employee Health Plan-CDHP**  
**Coverage Period:** 01/01/2014 through 12/31/2014  
**Summary of Benefits and Coverage:** What this Plan Covers & What it Costs  
**Coverage for:** Individual & Family  
**Plan Type:** PPO/HDHP  

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is your share of the costs of a covered service, calculated as a percent of the allowed amount for the service. For example, if the plan's allowed amount for an overnight hospital stay is $1,000, your coinsurance payment of 20% would be $200. This may change if you haven't met your deductible.
- The amount the plan pays for covered services is based on the allowed amount. If an out-of-network provider charges more than the allowed amount, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the allowed amount is $1,000, you may have to pay the $500 difference. (This is called balance billing.)
- This plan may encourage you to use Access Health, Ohio PPO Connect or Multiplan (if out-of-area) providers by charging you lower deductibles, copayments, and coinsurance amounts.

<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>Tier I - Access Health Provider</th>
<th>Tier II - Other in-network Provider</th>
<th>Tier III - Out-of-network Provider</th>
<th>Limitations &amp; Exceptions</th>
</tr>
</thead>
<tbody>
<tr>
<td>If you visit a health care provider’s office or clinic</td>
<td>Primary care visit to treat an injury or illness</td>
<td>No charge after deductible</td>
<td>30% coinsurance after deductible</td>
<td>50% coinsurance after deductible</td>
<td>None.</td>
</tr>
<tr>
<td></td>
<td>Specialist visit</td>
<td>No charge after deductible</td>
<td>30% coinsurance after deductible</td>
<td>50% coinsurance after deductible</td>
<td>If referral not obtained through Access Health, covered expenses reduced by 50% for Tier I &amp; Tier II visits &amp; office-based services and not covered for Tier III for office-based services.</td>
</tr>
<tr>
<td></td>
<td>Other practitioner office visit</td>
<td>No charge after deductible</td>
<td>30% coinsurance after deductible</td>
<td>50% coinsurance after deductible</td>
<td>Applies to chiropractic/osteopathic manipulation services. Covered expenses reduced by 50% if no referral at Tier I &amp; II levels, and not covered at Tier III. Pre-certification required for x-rays other than routine neck/spine.</td>
</tr>
<tr>
<td></td>
<td>Preventive care/screening/immunization</td>
<td>No charge</td>
<td>No charge</td>
<td>50% coinsurance, no deductible</td>
<td>Colonoscopy not covered unless provided at specified Tier I provider.</td>
</tr>
<tr>
<td>If you have a test</td>
<td>Diagnostic test (x-ray, blood work)</td>
<td>No charge after deductible</td>
<td>30% coinsurance after deductible</td>
<td>50% coinsurance after deductible</td>
<td>No charge after deductible for laboratory. Not covered out-of-network for specialist if no referral.</td>
</tr>
</tbody>
</table>

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<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>Your cost if you use an</th>
<th>Limitations &amp; Exceptions</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Tier I - Access Health) Provider</td>
<td>Tier II – Other in-network Provider</td>
</tr>
<tr>
<td>Imaging (CT/PET scans, MRIs)</td>
<td>No charge after deductible</td>
<td>Not covered</td>
<td>Not covered</td>
</tr>
<tr>
<td>If you need drugs to treat your illness or condition</td>
<td>Generic drugs</td>
<td>Not covered</td>
<td>40% co-insurance after deductible</td>
</tr>
<tr>
<td></td>
<td>Preferred brand drugs</td>
<td>Not covered</td>
<td>40% co-insurance after deductible</td>
</tr>
<tr>
<td></td>
<td>Non-preferred brand drugs</td>
<td>Not covered</td>
<td>40% co-insurance after deductible</td>
</tr>
<tr>
<td></td>
<td>Specialty drugs</td>
<td>Not covered</td>
<td>40% co-insurance after deductible</td>
</tr>
<tr>
<td>If you have outpatient surgery</td>
<td>Facility fee (e.g., ambulatory surgery center)</td>
<td>No charge after deductible</td>
<td>30% co-payment after deductible</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>No charge after deductible</td>
<td>30% co-payment after deductible</td>
</tr>
<tr>
<td>If you need immediate medical attention</td>
<td>Emergency room services</td>
<td>$75 co-payment after deductible</td>
<td>$75 co-payment after deductible</td>
</tr>
<tr>
<td></td>
<td>Emergency medical transportation</td>
<td>No charge after deductible</td>
<td>No charge after deductible</td>
</tr>
<tr>
<td></td>
<td>Urgent care</td>
<td>$35 co-payment after deductible</td>
<td>$35 co-payment after deductible</td>
</tr>
</tbody>
</table>

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If you aren’t clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at cciio.cms.gov/resources/other/index.html#sbcug or call 1-800-686-8425 to request a copy.
<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>Tier I - Access Health (Provider)</th>
<th>Tier II - Other In-Network Provider</th>
<th>Tier III - Out-of-Network Provider</th>
<th>Limitations &amp; Exceptions</th>
</tr>
</thead>
<tbody>
<tr>
<td>If you have a hospital stay</td>
<td>Facility fee (e.g., hospital room)</td>
<td>No charge after deductible</td>
<td>30% co-insurance after deductible</td>
<td>50% co-insurance after deductible</td>
<td>Pre-certification required. Limited to 120 days per calendar year.</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fee</td>
<td>No charge after deductible</td>
<td>30% co-insurance after deductible</td>
<td>50% co-insurance after deductible</td>
<td>None.</td>
</tr>
<tr>
<td>If you have mental health, behavioral health, or substance abuse needs</td>
<td>Mental/Behavioral health outpatient services</td>
<td>No charge after deductible</td>
<td>30% co-insurance after deductible</td>
<td>50% co-insurance after deductible</td>
<td>Penalties listed above apply if no referral for in-office specialist.</td>
</tr>
<tr>
<td></td>
<td>Mental/Behavioral health inpatient services</td>
<td>No charge after deductible</td>
<td>30% co-insurance after deductible</td>
<td>50% co-insurance after deductible</td>
<td>Pre-certification required.</td>
</tr>
<tr>
<td></td>
<td>Substance use disorder outpatient services</td>
<td>No charge after deductible</td>
<td>30% co-insurance after deductible</td>
<td>50% co-insurance after deductible</td>
<td>Penalties listed above apply if no referral for in-office specialist.</td>
</tr>
<tr>
<td></td>
<td>Substance use disorder inpatient services</td>
<td>No charge after deductible</td>
<td>30% co-insurance after deductible</td>
<td>50% co-insurance after deductible</td>
<td>Pre-certification required.</td>
</tr>
<tr>
<td>If you are pregnant</td>
<td>Prenatal and postnatal care</td>
<td>No charge after deductible</td>
<td>30% co-insurance after deductible</td>
<td>50% co-insurance after deductible</td>
<td>None.</td>
</tr>
<tr>
<td></td>
<td>Delivery and all inpatient services</td>
<td>No charge after deductible</td>
<td>30% co-insurance after deductible</td>
<td>50% co-insurance after deductible</td>
<td>Pre-certification required after 48 for normal delivery or 96 hours for C-section.</td>
</tr>
<tr>
<td>If you need help recovering or have other special health needs</td>
<td>Home health care</td>
<td>Not applicable</td>
<td>30% co-insurance after deductible</td>
<td>50% co-insurance after deductible</td>
<td>Pre-certification required. 30 visits per calendar year.</td>
</tr>
<tr>
<td></td>
<td>Rehabilitation services</td>
<td>No charge after deductible</td>
<td>30% co-insurance after deductible</td>
<td>50% co-insurance after deductible</td>
<td>20 sessions per episode for physical and occupational therapy. Additional sessions must be pre-approved. Speech therapy must be pre-certified after initial evaluation. Pre-certification also required for radiation therapy &amp; dialysis.</td>
</tr>
</tbody>
</table>

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# Fairfield Medical Center Employee Health Plan-CDHP

**Coverage Period:** 01/01/2014 through 12/31/2014  
**Summary of Benefits and Coverage:** What this Plan Covers & What it Costs  
**Coverage for:** Individual & Family | Plan Type: PPO/HDHP

## Table: Common Medical Event, Services You May Need, Cost, and Limitations

<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>Your cost if you use an</th>
<th>Limitations &amp; Exceptions</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Tier I - Access Health Provider</td>
<td>Tier II - Other in-network Provider</td>
</tr>
<tr>
<td>Habilitation services</td>
<td>No charge after deductible</td>
<td>30% co-insurance after deductible</td>
<td>50% co-insurance after deductible</td>
</tr>
<tr>
<td>Skilled nursing care</td>
<td>No charge after deductible</td>
<td>30% co-insurance after deductible</td>
<td>50% co-insurance after deductible</td>
</tr>
<tr>
<td>Durable medical equipment</td>
<td>No charge after deductible</td>
<td>30% co-insurance after deductible</td>
<td>50% co-insurance after deductible</td>
</tr>
<tr>
<td>Hospice service</td>
<td>No charge after deductible</td>
<td>30% co-insurance after deductible</td>
<td>50% co-insurance after deductible</td>
</tr>
<tr>
<td><strong>If your child needs dental or eye care</strong></td>
<td><strong>Eye exam</strong></td>
<td>Not covered, except as noted</td>
<td>Not covered, except as noted</td>
</tr>
<tr>
<td></td>
<td><strong>Glasses</strong></td>
<td>Not covered</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td><strong>Dental check-up</strong></td>
<td>Not covered</td>
<td>Not covered</td>
</tr>
</tbody>
</table>

**Excluded Services & Other Covered Services:**

- Acupuncture,
- Benefits paid as a result of injuries caused by another party may need to be repaid to the health plan or paid for by another party under certain circumstances,
- Cosmetic surgery, except following injury, to restore function for congenital defect of child or breast reconstruction following mastectomy,
- Dental care (Adult and child), except injury to teeth started within 31 days & completed within 6 months, removal of full & partial bony impactions, gingivectomy & alveolotomies,
- Hearing aids, including cochlear implants, and exams for prescription and fitting of hearing aids,
- Infertility treatment, including work-up,
- Long-term care,
- Private duty nursing, except as covered through home health,
- Routine eye care (Adult and child),
- Routine foot care, and
- Weight loss programs.

**Questions:** Call 1-800-686-8425 or visit us at www.medben.com.

If you aren’t clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at ccio.cms.gov/resources/other/index.html#sbhcg or call 1-800-686-8425 to request a copy.
Other Covered Services (This isn’t a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Chiropractic care, limited to manipulations & routine x-rays of neck/spine (unless approved), and to 20 visits per calendar year.
- Bariatric surgery for morbid obesity, limited to $20,000 per lifetime, and
- Non-emergency care when traveling outside the U.S., unless purpose of travel was to obtain treatment.

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending on the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a premium, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may apply.

For more information on your rights to continue coverage, contact the plan in care of MedBen’s Customer Service Department at 1-800-686-8425. You may also contact your state insurance department or the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebia.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to appeal or file a grievance. For questions about your rights, this notice, or assistance, you can contact: MedBen’s Customer Service Department at 1-800-686-8425, or e-mail MedBen at www.medben.com or the U.S. Department of Labor’s Employee Benefits Security Administration at 1-866-444-ELBA (3272) or www.dol.gov/ebia/healthreform. Additionally, a consumer assistance program may be available in your state to help you file your appeal. A list of states with Consumer Assistance Programs is available at www.healthcare.gov/using-insurance/managing/consumer-help/index.html.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as “minimum essential coverage.” This plan or policy does provide minimum essential coverage.

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). This health coverage does meet the minimum value standard for the benefits it provides.

Language Access Services:

Para obtener asistencia en Español, llame al 1-800-862-6704.

To see examples of how this plan might cover costs for a sample medical situation, see the next page.

Questions: Call 1-800-686-8425 or visit us at www.medben.com.

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About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

### Having a baby (normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays:** $4,830
- **Patient pays:** $2,910

<table>
<thead>
<tr>
<th>Sample care costs</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital charges (mother)</td>
<td>$2,700</td>
</tr>
<tr>
<td>Routine obstetric care</td>
<td>$2,100</td>
</tr>
<tr>
<td>Hospital charges (baby)</td>
<td>$900</td>
</tr>
<tr>
<td>Anesthesia</td>
<td>$900</td>
</tr>
<tr>
<td>Laboratory tests</td>
<td>$500</td>
</tr>
<tr>
<td>Prescriptions</td>
<td>$200</td>
</tr>
<tr>
<td>Radiology</td>
<td>$200</td>
</tr>
<tr>
<td>Vaccines, other preventive</td>
<td>$40</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>$7,540</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Patient pays:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Deductibles</strong></td>
<td>$2,500</td>
</tr>
<tr>
<td><strong>Co-pays</strong></td>
<td>$0</td>
</tr>
<tr>
<td><strong>Co-insurance</strong></td>
<td>$10</td>
</tr>
<tr>
<td><strong>Limits or exclusions</strong></td>
<td>$400</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>$2,910</strong></td>
</tr>
</tbody>
</table>

### Managing type 2 diabetes (routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays:** $1,800
- **Patient pays:** $3,600

<table>
<thead>
<tr>
<th>Sample care costs</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Prescriptions</td>
<td>$2,900</td>
</tr>
<tr>
<td>Medical Equipment and Supplies</td>
<td>$1,300</td>
</tr>
<tr>
<td>Office Visits and Procedures</td>
<td>$700</td>
</tr>
<tr>
<td>Education</td>
<td>$300</td>
</tr>
<tr>
<td>Laboratory tests</td>
<td>$100</td>
</tr>
<tr>
<td>Vaccines, other preventive</td>
<td>$100</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>$5,400</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Patient pays:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Deductibles</strong></td>
<td>$2,500</td>
</tr>
<tr>
<td><strong>Co-pays</strong></td>
<td>$0</td>
</tr>
<tr>
<td><strong>Co-insurance</strong></td>
<td>$900</td>
</tr>
<tr>
<td><strong>Limits or exclusions</strong></td>
<td>$200</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>$3,600</strong></td>
</tr>
</tbody>
</table>

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**Questions:** Call 1-800-686-8425 or visit us at www.medben.com.

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Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don’t include premiums.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren’t specific to a particular geographic area or health plan.
- The patient’s condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network providers. If the patient had received care from out-of-network providers, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how deductibles, copayments, and coinsurance can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn’t covered or payment is limited.

Does the Coverage Example predict my own care needs?

- **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor’s advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

- **No.** Coverage Examples are not cost estimators. You can’t use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your providers charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

- Yes. When you look at the Summary of Benefits and Coverage for other plans, you’ll find the same Coverage Examples. When you compare plans, check the “Patient Pays” box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

- Yes. An important cost is the premium you pay. Generally, the lower your premium, the more you’ll pay in out-of-pocket costs, such as copayments, deductibles, and coinsurance. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

Questions: Call 1-800-686-8425 or visit us at www.medben.com.
If you aren’t clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at www.dol.gov/whd or call 1-800-686-8425 to request a copy.
Health Savings Account (HSA)

Requirement: Must be enrolled in the Consumer Driven Health Plan (CDHP)

Eligibility: Full-time/Part-time
Upon Employment

Maximum Contribution Per Year: $3,000/Single and $6,450/Family
(Includes the FMC contribution of $325 per covered members)

A Health Savings Account (HSA) helps you plan and save money tax-free for qualified medical, dental, and vision expenses. To be eligible for a HSA, you must be enrolled in the Consumer Driven Health Plan. A health savings account offers convenience and flexibility, plus unused funds can roll over from year to year. A health savings investment account is for individuals who like to set aside tax-free money for future medical expenses.

You may open a Health Savings Account (HSA) at a banking facility of your choice. Fairfield Medical Center contributes $325, annually, per covered members into your Health Savings Account. You must provide Human Resources your HSA bank name, type of account (checking or savings HSA), routing and account numbers to deposit payroll deductions and/or receive the FMC contribution of $325 per covered member.

The account is owned by the individual (not the employer). The individual decides:

- Whether he or she should contribute;
- How much to use for medical expenses;
- Which medical expenses to pay from the account; and
- Whether to pay for medical expenses from the account or save the account for future use.

If you enroll in the Consumer Driven Health Plan and have a HSA account, you may also elect a Limited Purpose Spending Account. This account allows you to have additional pre-tax money up to $2,500 per year withheld from your paycheck for the purpose of dental and vision expenses only. Reimbursement will only be for eligible expenses incurred during the 12-month calendar year plus the first two and one-half months of the following calendar year. Any money left in the account at the end of that time will be claimed by the IRS.
Flexible Spending Account-Medical or Limited Purpose

Eligibility: Full-time/Part-time/Non-Benefit (Non-Benefit is not eligible for Limited Purpose)
Upon Employment
Enroll within 30 days of employment date or eligibility

Maximum Contribution Per Year: $2,500 Single/Family

The Flexible Spending Account (FSA) offers you a way to pay for medical, dental and vision expenses, on a pre-tax basis up to $2,500 per year, that are not covered under insurance. Reimbursement will only be for eligible expenses incurred during the 12-month calendar year plus the first 2 and one-half months of the following calendar year. Any money left in the account at the end of that time will be claimed by the IRS. This is a federally granted program.

** If you have a balance at the end of the current calendar year, you have until March 14th of the next year to have a service done and apply it towards the last year’s balance. You must use a paper reimbursement form to exhaust the balance. Ex: If you have an appointment in January or February of 2015, you can use the remaining money from 2014 to pay for the expense, but you need to use a paper application to get reimbursed. Do not use your Benny Card at that point or the expense will go against the current year (2015). The forms are available at MedBen.com or in HR.

The Limited Purpose plan is designed for those participants who are enrolled in the Consumer Driven Health Plan AND have a Health Savings Account (HSA). The Limited Purpose Spending Account can only be used for dental and vision expenses.

A Benny Debit Card, a special-purpose Visa® Card, is issued from MedBen to pay for qualified health care expenses. MedBen may ask for you for receipts to verify the expenses paid for with your Benny Card. If you do not use your Benny Card, you may also mail a paper claim form with attached receipts directly to MedBen. For additional FSA information and a list of eligible expenses, go to www.medben.com.

Flexible Spending Account-Dependent Care

Eligibility: Full-time/Part-time/Non-Benefit
Upon Employment
Enroll within 30 days of employment date or eligibility

Maximum Contribution: Up to $5,000 per year, or $2,500 if married and filing a separate income tax return.

The Flexible Spending Dependent Care allows you to pay for qualified dependent care expenses on a pre-tax basis up to $5,000 per year, or $2,500 if married and filing a separate income tax return (ONLY work-related child and/or Adult Day Care Expenses). Each pay period, you will have a specified amount of pre-tax money deducted from your paycheck to cover your dependent care expenses. It is important to be conservative in making elections because any unused funds following the close of the plan year are not refundable back to you. This is a federally granted program.

You will complete a form in Human Resources with the amount needed to pay for dependent care expenses. The deadline to submit the request is each payday to receive the amount direct deposited to your account on Friday of the off pay week.
Dental insurance can be elected for yourself, spouse, and dependent children to age 26. Refer to the provider directory at www.superiordental.com for a list of participating (In-Network) providers. In-Network providers offer savings by agreeing to charge you based on a negotiated maximum allowable contracted fee schedule. A participating provider has agreed not to charge you any amount for services above the negotiated maximum allowable fee amount. If you choose to seek care from a non-participating (Out-of-Network) provider, the billed amount may be above that charged by a participating provider and you will be responsible for paying the provider the balance remaining.

There are two dental plan options.

<table>
<thead>
<tr>
<th></th>
<th>Core Plan</th>
<th>Premium Per Pay</th>
<th>Enhanced Plan</th>
<th>Premium Per Pay</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employee</td>
<td>$ 7.67</td>
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<table>
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<tr>
<th>Covered Services</th>
<th>Core</th>
<th>Enhanced</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Diagnostic and Preventive Services</strong> - includes exams by a general dentist, cleanings, fluoride, and space maintainers, full mouth x-rays or panoramic survey</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td><strong>Basic Services</strong></td>
<td>50%</td>
<td>80%</td>
</tr>
<tr>
<td><strong>Major Services</strong></td>
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<td>50%</td>
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<tr>
<td><strong>Contract Maximum Per Member</strong></td>
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<tr>
<td><strong>Deductible</strong></td>
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<td>None</td>
</tr>
<tr>
<td><strong>Orthodontic Services</strong> - includes braces (under 20 years of age)</td>
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<td>50%</td>
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<tr>
<td><strong>Lifetime Ortho Max Per Member</strong></td>
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<td>$2,000</td>
</tr>
<tr>
<td><strong>Co-pay</strong></td>
<td>$10</td>
<td>$20</td>
</tr>
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</table>
**VSP Vision Benefits Summary**

**Eligibility:** Full-time/Part-time/Non-Benefit
Upon Employment
Enroll within 30 days of employment date or eligibility

**Contact Info:** Vision Service Plan
800-877-7195
www.vsp.com

**Premium Per Pay:**
- Employee $7.40
- Employee +1 $14.81
- Family $23.84

Vision insurance can be elected for yourself, spouse, and dependent children to age 26. Refer to the provider directory at www.vsp.com for a list of participating VSP doctors.

**WellVision Exam® focuses on your eye health and overall wellness** - $10.00 co-pay -- every calendar year

**Prescription Glasses** - $15.00 co-pay

**Frame** -- every calendar year (Co-pay included in prescription glasses)
- $120 allowance for a wide selection of frames; $140 allowance for featured frame brands
- 20% off amount over your allowance

**Lenses** -- every calendar year (Co-pay included in prescription glasses)
- Single vision, lined bifocal and lined trifocal lenses

**Lens Options** – Progressive lenses, tints/Photochromic lenses-Transitions, polycarbonate lenses, average 35-40% off other lens options

~ OR ~

**Contact Lens Care (instead of glasses)**
- Up to $60 co-pay -- every calendar year
- $105.00 allowance for contacts; co-pay does not apply
- Contact lens exam (fitting and evaluation)

**Diabetic Eyecare Plus Program** - $20.00 co-pay - ask your VSP doctor for details.

**Extra Discounts and Savings:**
- **Glasses and Sunglasses**-30% off additional glasses and sunglasses, including lens options, from the same VSP doctor on the same day as your WellVision Exam. Or get 20% off from any VSP doctor within 12 months of your last WellVision Exam.
- **Retinal Screening**-Guaranteed pricing on retinal screening as an enhancement to your WellVision Exam.
- **Laser Vision Correction**-Average 15% off the regular price or 5% off the promotional price; discounts only available from contracted facilities. After surgery, use your frame allowance (if eligible) for sunglasses from any VSP doctor.

VSP guarantees service from VSP doctors only. In the event of a conflict between this information and your organization's contract with VSP, the terms of the contract will prevail.

Visit vsp.com for details on coverage with Other Providers.
Short Term Disability (STD)

After 90 days of employment, a short term disability benefit is offered to you. This benefit, in conjunction with Family Medical Leave Act (FMLA) and Paid Time Off (PTO), covers illness, injuries and hospitalization while under a physician’s care. You receive a weekly benefit equal to 65% of your weekly earnings (based on income three months prior to the disability), to a maximum of $3,000 per week. PTO hours may be used to make up the 35% difference. There is a seven day elimination period for each claim before the benefit begins to pay. If you have a PTO balance, PTO must be taken during the seven day elimination period.

Level of Coverage/Premium Per Pay:
26 weeks/$19.00; 18 weeks/$14.00; 13 weeks/$9.00; 9 weeks/$6.00

If you currently have benefits and elect this benefit, your coverage will be medically underwritten by Unum and you are REQUIRED to complete an Evidence of Insurability (EOI) form.

If you currently have STD and change your coverage level, you do not need to complete an EOI form. If you are unsure if you need to complete an EOI form, please contact Human Resources.

NOTE: Newly hired employees, or new to benefit status are the ONLY times short term disability is a guarantee issue without completing an Evidence of Insurability (EOI) form.

Group Life Insurance

Eligibility: Full-time/Part-time/Non-Benefit
Upon Employment
Enroll within 30 days of employment date or eligibility

If you are a full-time, part-time or non-benefit employee, FMC offers you the option to elect group life insurance up to five times your annual salary. The level of coverage you qualify for depends on your position classification.

Options:  
Level of Coverage  
One time up to five times annual salary  
$7,500 flat benefit  

Premium Per Pay  
$1.54  
$.77
Unum

Long Term Disability

Eligibility: Full-time/Part-time/Non-Benefit
Upon Employment
Enroll within 30 days of employment date or eligibility

Long Term Disability coverage can be elected through Unum for yourself at low group rates. The elimination period is after 180 days of disability. The coverage is 50% of your monthly earnings to a maximum of $13,500. The benefit duration is based on your age when the disability occurs. If your disability occurs before age 60, benefits will be payable until age 65. If your disability occurs after age 60, benefits will be paid according to a benefit duration schedule.

Your coverage will be medically underwritten by Unum and you are REQUIRED to complete an Evidence of Insurability (EOI) form.

NOTE: Newly hired employees, or new to benefit status, are the ONLY times long term disability is a guarantee issue without completing an Evidence of Insurability (EOI) form. If you are unsure if you need to complete this form, please contact Human Resources.

Unum

Accidental Death & Dismemberment (AD&D)

Eligibility: Full-time/Part-time/Non-Benefit
Employee’s Spouse and/or Child(ren)
Upon Employment
Enroll within 30 days of employment date or eligibility

Requirement: Employee must elect this benefit in order to enroll spouse and/or child(ren)

You may elect Accidental Death & Dismemberment for yourself or coverage for family members at group discounted rates through payroll deduction. AD&D coverage helps protect against financial loss if you or a family member are severely injured or killed in an accident. You may purchase for yourself up to five times your salary in increments of $10,000, not to exceed $500,000. You may purchase for your spouse up to 100% of your elected coverage in increments of $5,000, not to exceed $500,000. You may purchase for your children up to 100% of your elected coverage in increments of $2,000, not to exceed $10,000. Children are covered up to age 19. If the child is a full-time student, coverage is to age 23.

Accidental Death & Dismemberment is always a guarantee issue. It is not subject to completion of an Evidence of Insurability (EOI) form.
You may elect supplemental life insurance for yourself or coverage for your family members at group discounted rates through payroll deduction. You may purchase for yourself up to five times your salary in increments of $10,000, not to exceed $500,000. You may purchase for your spouse up to 100% of your elected coverage in increments of $5,000, not to exceed $500,000. You may purchase for your children up to 100% of your elected coverage in increments of $2,000, not to exceed $10,000. Children are covered up to age 19. If the child is a full-time student, coverage is to age 23.

NOTE: If you are a current employee in a benefit status and you newly elect this benefit, you are REQUIRED to complete the Evidence of Insurability (EOI) form for the entire amount of coverage. The guarantee issue for yourself is up to $140,000, and up to $25,000 for your spouse. Any term life insurance coverage over the guarantee issue amount(s) will be subject to Evidence of Insurability (EOI). This includes newly hired employees or new to benefit status.

You may elect Long Term care insurance through Unum for yourself or your family. Long Term care is the assistance received when someone needs help with two or more activities of daily living: such as dressing, bathing, going to the bathroom, eating or moving about – or when someone suffers a severe cognitive impairment. This care could be provided in the home, in an assisted living, or residential care facility, or in a skilled nursing facility such as a nursing home.

Any coverage elected for you or your dependents will be medically underwritten by Unum.
Benefit Contact Information

MedBen Health Insurance: www.medben.com
Customer Service Hours: 8:00 am to 6:30 pm, Monday – Friday
Customer Service Phone Number: 800-686-8425 or 740-522-8425
Fairfield Medical Center: 740-687-8017

Fairfield Medical Center MedBen Group Number: 10404
Medical ID No: Employee’s Social Security Number (may provide the last 4 digits)
Electronic Claims Payor ID Number: 74323

Coordinated Care Health Plan: $10 co-pay – Primary Care Provider
Consumer Driven Health Plan: $0 co-pay – Primary Care Provider
$25 co-pay – Specialist
$0 co-pay - Specialist

MedBen Flexible Spending Account (FSA) questions and Benny Card: 800-423-3151

Quality Care Partners (QCP) - QCP Referral or Pre-cert Phone: 888-258-7621; Nurse Hotline: 888-862-4441
➢ To verify health care providers
➢ To receive maximum benefits for specialty care or services requiring precertification, you must obtain authorization from QCP prior to receiving services
➢ You must notify QCP within 24 hours of an emergency hospitalization, or the next business day for an admission occurring on a weekend or holiday
➢ Referral & precertification requests can be sent by confidential fax to: 740-455-8817; or by phone: 888-258-7621

Ohio PPO Connect Providers Website: www.ohioppoconnect.com; or by phone: 888-258-7621

Fairfield Medical Center Prescription Drug Plan (KPP Network): www.kpp-rx.com; rxplans@kroger.com
Rx Customer Service Phone Number: 800-482-1285
Rx ID Number: Employee Number Group Number: 0126

Superior Dental: www.superiordental.com; or the Customer Service Phone Number: 800-762-3159
Core Group Plan Number: D6400-2014
$10 co-pay (This amount is applied to oral evaluations in the Preventive Category only and is to be paid per covered person, per occurrence, at the time of the visit.)
Enhanced Group Plan Number: D6405-2014
$20 co-pay (This amount is applied to oral evaluations in the Preventive Category only and is to be paid per covered person, per occurrence, at the time of the visit.)

Vision Service Plan: www.vsp.com; or the Customer Service Phone Number: 800-877-7195
ID Number: 12130297
Division Number: 0001

Unum Life Insurance Company of America: www.unum.com; or by phone: 800-343-5406

Fairfield Nation Bank/Pension 401k: www.retirementlogin.com/save2retire; or by phone: 740-681-8246

Colonial Life: www.coloniallife.com; or by phone: 800-325-4368

MetLife Insurance Company: 614-259-1665 or 740-920-4089
Paid Time Off (PTO)

Eligibility: Full-time/Part-time
Non-Benefit Status is not eligible for PTO
Upon Employment (available to use after 90 days of employment; except for a recognized holiday)

FMC recognizes that it is beneficial for employees to take time off from work for rest and relaxation. FMC provides Paid-Time-Off (PTO) for time taken away from work, scheduled and unscheduled, including recognized holiday, vacation, and illness, by eligible employees. The Paid-Time-Off (PTO)/Non-benefit Time Off (NBTO) policy applies to all FMC and Fairfield Health Professionals (FHP) employees, unless the employee has an employment contract that supersedes this policy.

PTO is accrued each pay, based on the regular hours worked by the employee, beginning with the first day of work as an eligible employee. The amount of accrual is based on years of service. The maximum number of hours an employee can keep in his/her PTO account is 283 hours. Once an employee reaches that amount, the accrual of PTO will cease until the PTO totals fall below 283 hours.

Full-time employees must take a minimum of 128 hours of PTO or NBTO during the calendar year; part-time employees must take a minimum of 64 hours PTO or NBTO each calendar year.

Employees may voluntarily cash-in PTO hours quarterly.

Please refer to the Paid-Time-Off (PTO)/Non-Benefit Time Off Policy on the FMC Intranet to review the entire policy.

Tuition Assistance

Eligibility: Full-time/Part-time/Non-Benefit
May request assistance after 90 days of employment

The tuition assistance program provides tax-free educational assistance to full-time, part-time and non-benefit employees who have completed 90 days of employment. Eligible employees may receive up to $5,250 tuition assistance per year at no cost to them.

Courses approved for reimbursement must be conducted by accredited colleges, schools, or online programs that fulfill requirement credits toward a degree. This includes payments for tuition, fees, and similar expenses, books, supplies and equipment.

Tuition assistance is paid to the employee upon successful completion of the semester or courses within a semester. Proof of payment for approved courses or expenses and grades must be submitted with the tuition assistance application.

In completing an application, the employee agrees to remain an employee of the Center in a full-time or part-time status at least one year for each semester/course reimbursed. The time commitment starts when the reimbursement is paid to the employee and ends one year from the reimbursement date.

Please refer to the Tuition Assistance policy for more information.
Matrix Employee Assistance Program

- Everyone experiences personal problems from time to time, but sometimes these problems can be overwhelming. Fairfield Medical Center knows that employees distracted by personal problems cannot do their best on the job. Matrix is our Employee Assistance Program (EAP). FMC is encouraging you and your family to seek help with any issues, whenever they arise, at no cost to you.

- Below are just a few highlights to our EAP benefit:
  - Matrix EAP services are strictly confidential:
    - No information can be released without your written consent.
  - Matrix offers a number of services:
    - Work/Life balance; Eldercare; Drug abuse; Legal/Financial problems, and Parenting issues, just to name a few.
  - The EAP program includes the following benefits:
    - 8 free visits per episode, per year
    - Available to full-time and part-time employees
    - Available to spouses and dependent children
    - Crisis hotline available 24/7/365
  - The EAP program is offered at no cost to employees.
  - Matrix’s website, www.matrixpsych.com, has special pages for you to review. These pages offers you and your families a number of helpful resources. If you have additional questions, please contact Matrix at (614) 475-9500, or (800) 886-1171.
FMLA Coverage:
FMC provides all eligible employees up to 12 weeks of unpaid FMLA leave during any 12 month period.

Eligibility Requirements:
An FMLA eligible employee is an employee who has been employed by FMC for at least 12 months and worked at least 1250 hours. The 12 months does not need to be consecutive.

Basic Leave Entitlement:
Under the Family and Medical Leave Act, FMC must grant eligible employees up to a total of 12 work weeks of unpaid leave during any 12 month period for the following reasons:
- For incapacity due to pregnancy, prenatal medical care or childbirth;
- To care for the employee’s child after birth, or placement for adoption or foster care;
- To care for the employee’s spouse, son or daughter, or parent, who has a serious health condition; or
- For a serious health condition that makes the employee unable to perform the employee’s job.

Definition of Serious Health Condition:
A serious health condition is an illness, injury, impairment, or physical or mental condition that involves either an overnight stay in a medical care facility, or continuing treatment by a health care provider for a condition that either prevents the employee from performing the functions of the employee’s job or prevents the qualified family member from participating in school or other daily activities.

Use of Leave:
An employee does not need to use this leave entitlement in one block. Leave can be taken intermittently or on a reduced leave schedule when medically necessary. Employees must make reasonable efforts to schedule leave for planned medical treatment so as not to unduly disrupt the employer’s operations.

Employee Responsibilities:
Employees must provide sufficient information for the employer to determine if the leave may qualify for FMLA protection and the anticipated timing and duration of the leave. Sufficient information may include that the employee is unable to perform job functions, the family member is unable to perform daily activities, the need for hospitalization or continuing treatment by a health care provider, or circumstances supporting the need for military family leave. Employees also must inform the employer if the requested leave is for a reason for which FMLA leave was previously taken or certified. Employees also may be required to provide a certification and periodic recertification supporting the need for leave.

Military FMLA:
Eligible employees with a spouse, son, daughter or parent on active duty or call of active duty status in the National Guard or Reserves in support of a contingency operation may use their 12-week unpaid leave for a qualified emergency arising from a family member’s active military duty. If those loved ones become seriously ill or injured while on active duty, coverage may be extended to 26 weeks of unpaid leave each year.

Additional Information:
If you have benefit premiums, FMC must continue that coverage while you are on leave. However, once you return to work, your missed benefit premiums will be deducted from your paychecks until they are up-to-date. For more details on FMLA guidelines, please see Human Resources.
Additional Benefits

**Adoption Assistance**
Upon 90 days of active employment, FMC will contribute up to $3,000 per 12 months with proof and final documentation of all attorney fees, court fees, medical expenses for both the child and adopting parent, as required during the adoption process and other reasonable and customary expenses that the employee is legally required to pay. Payment eligibility will be determined on a case-by-case basis.

**Auto/Home Owners Insurance with MetLife**
Fairfield Medical Center employees are provided the option of a MetLife Auto and Home Owners Policy. Automobile and homeowners insurance coverage can be purchased at special group rates. For more information, contact Doug Berling at 740-920-4089.

**Cafeteria Meals**
Employees are provided meals in FMC’s cafeteria at a discount.

**Colonial Life & Accident Insurance Company**
Personal insurance products are available through Colonial Life during the annual benefits open enrollment. Plans offered during the enrollment are Accident, Cancer, Critical Illness, Disability and Life insurance.

**Concierge Services**
Vanity Cleaners – pickup/delivery on Monday and Wednesday mornings in Human Resources. You work directly with Vanity Cleaners for payment of their services.

Automotive Services – several area business will pick-up your car for service while you work – there are parking spots reserved for concierge service on the top northeast corner of the garage (facing Ewing Street). Area businesses that provide this service are AAA Car Care, Buckeye Honda, Gary’s Sunoco, Kumler, Bobby Layman, Pipers Service Center and Taylor Chevrolet. You make the appropriate service appointment and payments arrangements and drop off your keys in the North Lobby for pick-up and delivery.

**Day Care Center**
Day Care is offered by Small Wonders Learning Center for employee’s children, ages 6 weeks to 14 years of age, at a group discount. Payment may be made through payroll deduction. For more information, contact Small Wonders at 740-654-8100.

**Direct Deposit - Direct Deposit is REQUIRED for all employees.** You should always have an active direct deposit account in Employee Self-Service.
Additional Benefits

Discount Directory – An Employee Discount Directory is available in Human Resources
- Many of the discounts are offered through COESRA (Central Ohio Employee Service and Recreation Association).
- Local area businesses may want to see your employee ID badge.
- The book is updated annually, however, you might want to call the business prior to any purchase to be sure of the discount availability.

Discount Tickets available in Human Resources
- Columbus Zoo and Newport Aquarium tickets are available throughout the year until they expire on 12/31.
- Zoombezi Bay and Kings Island tickets are available during the summer season. Cedar Point tickets are purchased by the employee online during the summer season using a promo code.
- Ticket prices are available in Human Resources.

Employee Activities Committee
Offers activities and events for employees throughout the year at group discount rates. A list of current activities is available on the FMC Intranet under the Employees Activities Link.

Employee Fitness Program
An Employee Fitness Center is available for employees to use during unscheduled hours. An annual fee of $65 is required for membership. Cardiopulmonary Fitness/Education can be reached at 740-687-8174.

Employee Health
FMC’s Employee Health Services assure that employees meet the required employment standards through monitoring and establishing preventative health measures whereby serving as an indicator for absenteeism due to employee illness. This program is available to all employees that may become ill or injured at work. A pre-employment physical assessment is required of any applicant after an offer of employment is made. This exam includes screening for the use of controlled substances and/or infectious diseases. These services will be compliant with The Joint Commission standards and Private Healthcare Information (PHI) legal requirements. Employees who become ill while at work may receive permission from their Supervisor to be examined by the Employee Health nurse or in the FMC Emergency Department. Work related injuries or illness will be covered by Workers’ Compensation and non-work related injuries or illness may be eligible for the covered employee’s medical benefit plan subject to member out-of-pocket expenses.

Group Legal - This benefit is offered for employees requiring legal services. You may enroll for this benefit anytime during the year and the premiums are payroll deducted. The enrollment application is available in Human Resources.
Additional Benefits

Kroger Plus Card Program – FMC has partnered with Kroger to offer a discount program that provides a discount of 5% on Private Select brand purchases in addition to the discount currently provided by using your Kroger Plus card. The additional 5% discount will automatically be calculated when you use your Kroger Plus card at checkout. You must complete an application to participate in the program. Application are available in Human Resources.

Lan-Fair Federal Credit Union - Employees may join Lan-Fair Federal Credit Union. To join, visit them at one of their two offices located in Lancaster and Pickerington. Membership information and required disclosures will be provided to you at that time. Their website is www.lanfairfcu.com.

Parking - FMC has designated parking areas for use by employees, volunteers, physicians, patients and visitors. Employees are required to register their vehicle and obtain a parking tag from Human Resources.

Tuition Trust - The information is available to apply through Ohio Tuition Trust for payroll deduction to purchase tuition units. The deduction amounts come back to Human Resources to process through Payroll. The Ohio Tuition Trust Authority includes the College Advantage which is Ohio’s direct 529 college savings program featuring tax-free savings and low fees.

Wellness - FMC provides employees online support, education and tools to support a healthy lifestyle. FMC also provides the “Community Wellness” newsletter. Each employee is risk stratified and health-coaching sessions are provided to incorporate small changes needed to make a difference in your Health Services offered to employees and dependent over the age of 12, such as massage therapy, outpatient therapy/sports clinic services, occupational therapy, women’s outpatient therapy services and exercise classes featuring yoga & Pilates.

For further information, please contact Human Resources at 740-687-8017.
Employee Separation/Resignation

For the following benefits, coverage is through the end of the month of your separation date: Coordinated Care Health Plan, Consumer Driven Health Plan, Dental and Vision. MedBen will mail COBRA information to you for health, dental, and vision benefits within 15 days after your coverage ends. You have 60 days from when your coverage ends to decide on continuation of these benefits through COBRA. If you have medical insurance, MedBen will also send you a letter of portability. If you have any questions on the COBRA process, contact MedBen at 1-800-686-8425.

Medical Spending (Flexible Spending Account) - Your Benny Card will be deactivated by MedBen when your coverage ends. You have 90 days after your coverage ends to submit hard copies of receipts to MedBen that were on or before your coverage end date. The form to submit with your receipts is available in Human Resources or at www.medben.com. Any services after your coverage ends will not be eligible for reimbursement. Any funds left in the account will be absorbed back into the Plan (this is a government regulation). If you have any questions on your Medical Spending account or Benny Card, contact MedBen at 1-800-686-8425.

For the following Unum policies, your coverage ends on the effective date of your separation and are portable policies: Group Life, Supplemental Life, Accidental Death & Dismemberment and Long Term Care. Portable Coverage - You may be eligible to take this coverage with you according to the terms outlined in Unum’s contract. You have 30 days to apply for portable coverage. Portability forms are available in Human Resources. You must submit the form and premium payment directly to Unum within 30 days of your resignation date. Unum’s contact number is 1-800-421-0344.

For the following Unum Disability Policies, your coverage ends on the effective date of your separation and they are not portable policies: Short Term and Long Term Disability.

- **Colonial Policies:** Contact Colonial at 1-800-325-4368 for policy options.
- **Health Savings Account:** This account is owned by you to manage.
- **FMC Pension/401(k) or Pension Loans:** Any questions you have on your pension account should be directed to Vincent Carpico at Fairfield National Bank. His phone number is 740-681-8246, or by email at vcarpico@fairfieldnationalbank.com. If you have a pension loan, you must make payment arrangements with Fairfield National Bank.
- **Pension 403(b):** Contact the investment professional responsible for your 403b plan.
- **Tuition Assistance:** If you have received tuition assistance in the past year, you must make payment arrangements with Human Resources to pay the assistance back to the Center, 740-687-8017.
- **Hospital Bill:** Any balance due may be taken out of your final paycheck or PTO payout check. If your balance exceeds those checks, you must make payment arrangements with Contracts & Collections, 740-687-8025.
- **Payroll Deduction Balances** (Super Shopper Program, Café, Books, Uniforms, Coffee Bar, etc.): Any balance due may be taken out of your final paycheck or PTO payout check. Any questions you may have regarding any deduction balances should be directed to Accounting at 740-687-8045.
- **Family Y:** Contact the Family Y, 740-654-0616, extension 242.
- **PTO – balance with one year of employment service:** If you have more than one year of service, your PTO balance will be paid out to you. The payout is normally the Friday following your last paycheck. The payout check will be mailed to your home address on file unless you make other arrangements with Accounting.
HEALTHCARE REFORM’S IMPACT ON BENEFITS

FMC has incorporated the following federal provisions of the Affordable Care Act. Under the Act effective on or before January 1, 2012:

COVERING DEPENDENT CHILDREN UP TO AGE 26
Adult children up to age 26 may be eligible to enroll in medical and prescription drug coverage through Fairfield Medical Center given they meet the following:
• Each of your natural or legally adopted children, each of your stepchildren, and each child under your legal guardianship;
• From birth until he/she reaches 26 years of age; and
• A child if you, the Employee, are named in a court order obligating you to provide health care coverage for a child.

100 PERCENT COVERAGE OF PREVENTIVE CARE SERVICES
The Affordable Care Act will make wellness and prevention services affordable and accessible by requiring health plans to cover in-network preventive services at 100 percent. The list of preventive services are determined by the government.

UNLIMITED LIFETIME MAXIMUM MEDICAL BENEFITS
An unlimited lifetime maximum will be implemented for medical benefits. There will be no longer be a $1.5 million limit per individual.

OVER THE COUNTER PHARMACUTICALS
You may not use your spending accounts (Flexible Spending or Health Savings Account) to purchase over-the-counter medications without a physician script effective January 1, 2011.

EMPLOYEE W-2 FORMS
FMC is required to include the cost of the health and pharmacy insurance benefits on the Employee W-2. This will not be a tax on the employee.

UNIFORM SUMMARY OF PLAN BENEFITS AND COVERAGE
Model forms will be issued by the government but nothing definitive has been released. This uniform summary is included in this 2014 Benefit Guide.

INDEPENDENT REVIEW ORGANIZATION (IRO)
Final member stage of claim appeals must be conducted by IRO.

EMERGENCY ROOM COVERAGE
In and out of network benefits may not have different out-of-pocket expenses.

HIPAA Private Healthcare Information (PHI) Compliance – Employee Health Benefits Plan

Fairfield Medical Center and all persons providing services to the Plan are required to comply with the Administrative Simplification Provisions of the Health Insurance Portability and Accountability Act of 1996 and the HITECH Provisions of the American Reinvestment and Recovery Act of 2009 which relate to the privacy, security and all regulations of Protected Health Information (PHI). Purpose The Plan collects and maintains a great deal of PHI about employees and their dependents covered under the Plan (“Members”). HIPAA requires Fairfield Medical Center to protect the privacy and security of PHI. The Fairfield Medical Center HIPAA Compliance Program implements the requirements set forth by HIPAA.

Notice of Privacy Practices
Fairfield Medical Center Health Plan will maintain a Notice of Privacy Practices and make it available to ALL members as required under HIPAA. The Notice of Privacy Practices will be mailed to ALL employees who enroll in coverage through the Fairfield Medical Center Health Benefits Plan.

Disclosures to Family and Friends
The member’s approval must be obtained prior to disclosing PHI to family members, friends, or others involved with the care of the member of payment for such care.

Disclosures to Family and Friends Procedure
You may allow family or friends to view your personal health information by signing a form available from FMC carriers and vendors. FMC will, also, maintain a form if you choose to complete it, but this authorization is limited to FMC and will not cover disclosures from carriers or vendors.
Notice of COBRA Continuation Coverage Rights
Fairfield Medical Center
“Continuation Coverage Rights Under COBRA”

Introduction
You are receiving this notice because you have recently become covered under a group health plan (the Plan). This notice contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. This notice generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.

The rights to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation of Coverage can become available to you when you would otherwise lose your group health coverage. It can also become available to other members of your family who are covered under the Plan when they would otherwise lose their group health coverage. For additional information about your rights and obligations under the Plan and under federal law, you should review the Plan’s Summary Plan Description or contact the Plan Administrator.

What is COBRA Continuation Coverage?
COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a “qualifying event”. Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a “qualified beneficiary”.

You, your spouse and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event.

Under the Plan, qualified beneficiaries who elect COBRA continuation coverage [choose and enter appropriate information: must pay or are not required to pay] for COBRA continuation coverage.

If you are an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because either one of the following qualifying events happens:
• The parent-employee dies;
• The parent-employee’s hours of employment are reduced;
• The parent-employee’s employment ends for any reason other than his or her gross misconduct;
• The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
• The parents become divorced or legally separated; or
• The child stops being eligible for coverage under the plan as a “dependent child.”

When is COBRA Coverage Available?
The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment, death of the employee [add if Plan provides retiree health: commencement of a proceeding in bankruptcy with respect to the employer, or the employee’s becoming entitled to Medicare benefits (under Part A, Part B, or both), the employer must notify the Plan Administrator of the qualifying event.

You must Give Notice of Some Qualifying Events
For the other qualifying events (divorce or legal separation of the employee and spouse or a dependent child’s losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days [after the qualifying event occurs. You must provide this notice to: the Total Rewards Coordinator.

How is COBRA Coverage Provided?
Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the employee, the employee’s becoming entitled to Medicare benefits (under Part A, Part B, or both) your divorce or legal separation, or a dependent child’s losing eligibility as a dependent child, COBRA continuation coverage lasts for up to a total of 36 months. When the qualifying event is the end of employment or reduction of the employee’s hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement.
**Notice of COBRA Continuation Coverage Rights**
Fairfield Medical Center

**Continuation Coverage Rights Under COBRA**

For example, if a covered employee becomes entitled to Medicare eight months before the date on which their employment terminates, COBRA continuation coverage for their spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months). Otherwise, when the qualifying event is at the end of employment or reduction of the employee’s hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

**Disability extension of 18-month period of continuation coverage**

If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage.

**Second qualifying event extension of 18-month period of continuation coverage**

If your family experiences another qualifying event while receiving 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to an additional months of COBRA continuation coverage, for a maximum of 36 months, if notice of the second qualifying event is properly given to the Plan. This extension may be available to the spouse and any dependent children receiving continuation coverage if the employee or former employee dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), or gets divorced or legally separated, or if the dependent child stops being eligible under the Plan as a dependent child, but only if the event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

**If You Have Questions**

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Officer of the U. S. Department of Labor’s Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and district EBSA Officers are available through EBSA’s website.)

**Keep Your Plan Informed of Address Changes**

In order to protect your family’s rights, you should keep the Plan Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

**Plan Contact Information, Customer Service** 800-826-9781 www.medben.com
NOTICE OF PRIVACY PRACTICES
THE Fairfield Medical Center EMPLOYEE HEALTH PLANS

THIS NOTICE DESCRIBES HOW PROTECTED HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

The terms of this Notice of Privacy Practices apply to the Fairfield Medical Center Health Plan (“Plan”). The Plan will share Protected Health Information of employees and dependents covered by the Plan (“Members”) as necessary to carry out treatment, payment, and health care operations as permitted by law. The Plan is required by law to maintain the privacy of Members’ Protected Health Information and to provide Members with notice of our legal duties and privacy practices with respect to the Member’s Protected Health Information. The Plan is required to abide by the terms of this Notice so long as it remains in effect. We reserve the right to change the terms of this Notice of Privacy Practices as necessary and to make the new Notice effective for all Protected Health Information maintained by the Plan.

Copies of this Notice and revised Notices may be obtained by making a written request to the Privacy Officer at Fairfield Medical Center Human Resources at 401 North Ewing St., Lancaster, OH 43130.

USES AND DISCLOSURES OF YOUR PROTECTED HEALTH INFORMATION

Your Authorization. Except as outlined below, we will not use or disclose your Protected Health Information for any purpose unless you have signed a form authorizing the use or disclosure. You have the right to revoke that authorization in writing unless we have taken any action in reliance on the authorization.

Disclosures for Treatment. We will make disclosures of your Protected Health Information as necessary for your treatment. For instance, a doctor or health facility involved in your care may request certain of your Protected Health Information that we hold in order to make decisions about your care.

Uses and Disclosures for Payment. We will make uses and disclosures of your Protected Health Information as necessary for payment purposes. For instance, we may use information regarding your medical procedures and treatment to process and pay claims, to determine whether services are medically necessary or to otherwise pre-authorize or certify services as covered under your health benefits plan. We may also forward such information to another health plan which may also have an obligation to process and pay claims on your behalf.

Uses and Disclosures for Health Care Operations. We will use and disclose your Protected Health Information as necessary, and as permitted by law, for our health care operations which include enrollment, underwriting, reinsurance, compliance, auditing, and other functions related to your health benefits plan. We may also disclose your Protected Health Information to a health care facility, health care professional, or another health plan for such things as quality assurance and case management, but only if that facility, professional, or plan also has or had a patient relationship with you.

Family and Friends Involved In Your Care. With your approval, we may from time to time disclose your Protected Health Information to designated family, friends, and others who are involved in your care or in payment for your care in order to facilitate that person’s involvement in caring for you or paying for your care. If you are unavailable, incapacitated, or facing an emergency medical situation and we determine that a limited disclosure may be in your best interest, we may share limited Protected Health Information with such individuals without your approval. We may also disclose limited Protected Health Information to a public or private entity that is authorized to assist in disaster relief efforts in order for that entity to locate a family member or other persons that may be involved in some aspect of caring for you.

Business Associates. Certain aspects and components of our services are performed through contracts with outside persons or organizations, such as auditing, actuarial services, legal services, etc. At times it may be necessary for us to provide certain of your Protected Health Information to one or more of these outside persons or organizations who assist us with our health care operations. In all cases, we require these business associates to appropriately safeguard the privacy of your information.

Communications With You. We may communicate with you regarding your claims, premiums, or other things connected with your health plan. You have the right to request communications regarding your Protected Health Information to be provided by alternative means or at alternative locations. We are not required to agree to most of these requests, but we will try to accommodate those that are reasonable. For instance, if you wish messages to not be left on voice mail or sent to a particular address, we will accommodate reasonable requests. If you believe that the alternative communication or location is necessary because disclosure of the information would endanger your health and safety, we will accommodate your request. You may request such confidential communication in writing and may send your request to the Privacy Officer at Fairfield Medical Center Human Resources at 401 North Ewing St., Lancaster, OH 43130.

Other Health-Related Products or Services. We may, from time to time, use your Protected Health Information to determine whether you might be interested in or benefit from treatment alternatives or other health-related programs, products or services which may be available to you as a Member of the Plan. For example, we may use your Protected Health Information to identify whether you have a particular illness, and contact you to advise you that a disease management program to help you manage your illness better is available to you as a Plan Member. We will not use your information to communicate with you about products or services which are not health-related without your written permission.
Other Uses and Disclosures. We are permitted or required by law to make certain other uses and disclosures of your Protected Health Information without your authorization.
• We may release your Protected Health Information for any purpose required by law;
• We may release your Protected Health Information for public health activities, such as required reporting of disease, injury, and birth and death, and for required public health investigations;
• We may release your Protected Health Information as required by law if we suspect child abuse or neglect; we may also release your Protected Health Information as required by law if we believe you to be a victim of abuse, neglect, or domestic violence
• We may release your Protected Health Information to the Food and Drug Administration if necessary to report adverse events, product defects, or to participate in product recalls;
• We may release your Protected Health Information to your Claims Administrator in the case of an appeal; provided, however, your claims administrator must certify that the information provided will be maintained in a confidential manner.
• We may release your Protected Health Information if required by law to a government oversight agency conducting audits, investigations, or civil or criminal proceedings;
• We may release your Protected Health Information if required to do so by a court or administrative ordered subpoena or discovery request; in most cases you will have notice of such release;
• We may release your Protected Health Information to law enforcement officials as required by law to report wounds and injuries and crimes;
• We may release your Protected Health Information to coroners and/or funeral directors consistent with law;
• We may release your Protected Health Information if necessary to arrange an organ or tissue donation from you or a transplant for you;
• We may release your Protected Health Information for certain research purposes when such research is approved by an institutional review FMC with established rules to ensure privacy;
• We may release your Protected Health Information if you are a member of the military as required by armed forces services; we may also release your Protected Health Information if necessary for national security or intelligence activities; and
• We may release your Protected Health Information to workers’ compensation agencies if necessary for your workers’ compensation benefit determination.
RIGHTS THAT YOU HAVE
Access to Your Protected Health Information. You have the right to copy and/or inspect much of the Protected Health Information that is retained on your behalf. All requests for access must be made in writing to the Privacy Officer at Fairfield Medical Center Human Resources at 401 North Ewing St., Lancaster, OH 43130 and signed by you or your representative.
Amendments to Your Protected Health Information. You have the right to request in writing that Protected Health Information that we maintain about you if it requires correction. We are not obliged to make all requested amendments but will give each request careful consideration. All amendment requests, in order to be considered by us, must be in writing, signed by you or your representative, and must state the reasons for the amendment/correction request. If an amendment or correction you request is made by us, we may also notify others who work with us and have copies of the uncorrected record if we believe that such notification is necessary. Your request for should be directed to the Privacy Officer at Fairfield Medical Center Human Resources at 401 North Ewing St., Lancaster, OH 43130.
Accounting for Disclosures of Your Protected Health Information. You have the right to receive an accounting of certain disclosures made by us of your Protected Health Information. Requests must be made in writing and signed by you or your representative. Accounting requests must be in writing and should be directed to the Privacy Officer at Fairfield Medical Center Human Resources Department, 401 North Ewing St., Lancaster, OH 43130.
Restrictions on Use and Disclosure of Your Protected Health Information. You have the right to request restrictions on certain of our uses and disclosures of your Protected Health Information for treatment, payment, or health care operations by notifying the Privacy Officer at Fairfield Medical Center Human Resources at 401 North Ewing St., Lancaster, OH 43130 of your request for a restriction in writing. We are not required to agree to your restriction request but will attempt to accommodate reasonable requests when appropriate and we retain the right to terminate an agreed-to restriction if we believe such termination is appropriate. In the event of a termination by us, we will notify you of such termination. You also have the right to terminate, in writing or orally, any agreed-to restriction to sending such termination notice to the Privacy Officer.
Complaints. If you believe your privacy rights have been violated, you can file a complaint with the Privacy Officer at Fairfield Medical Center Human Resources at 401 North Ewing St., Lancaster, OH 43130. You may also file a complaint with the Secretary of the U.S. Department of Health and Human Services in Washington D.C. in writing within 180 days of a violation of your rights. There will be no retaliation for filing a complaint.
FOR FURTHER INFORMATION
If you have questions or need further assistance regarding this Notice, you may contact the Privacy Officer at Fairfield Medical Center Human Resources at 401 North Ewing St., Lancaster, OH 43130. As a Member you retain the right to obtain a paper copy of this Notice of Privacy Practices, even if you have requested such copy by e-mail or other electronic means.
EFFECTIVE DATE
This Notice of Privacy Practices is effective December 1, 2012.
Fairfield Medical Center

Important Notices about Your Benefits

Recent Laws May Affect Your Medical Coverage
The lifetime limit on the dollar value of benefits under the Fairfield Medical Center Medical Benefit Plan no longer applies. Individuals whose coverage ended by reason of reaching a lifetime limit under the plan are eligible to enroll in the plan. Such individuals may request enrollment during the open enrollment period. Enrollment will be effective January 1, 2014. For more information contact the Human Resources at 740-687-8017. Notice of Special Enrollment Rights for the Fairfield Medical Center Medical Benefit Plan (“Plan”)

Loss of Other Coverage – 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 this 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 you or your dependents’ other coverage ends (or after the employer stops contributing toward the other coverage).

New Dependent as a Result of Marriage, Birth, Adoption or Placement for Adoption
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.

Effective April 1, 2009
If you or your dependents are eligible for coverage under the Plan, but are not enrolled, you or your dependents will be permitted to enroll for coverage under the Plan during the plan year if either of the following events occurs:

Termination of Medicaid or Children’s Health Insurance Plan (CHIP) Coverage
If you or your dependents are covered under a Medicaid plan or a CHIP and such coverage is terminated because you no longer satisfy the eligibility requirements and you request coverage under the Plan not later than 60 days after the date of termination of Medicaid or CHIP coverage.

Eligibility for Employment Assistance Under Medicaid or CHIP
If you or your dependents become eligible under Medicaid or CHIP (including under any waiver or demonstration project conducted under or in relation to such plan) for assistance in paying premiums for coverage under the Plan and you request coverage under the Plan not later than 60 days after the date you or your dependents are determined to be eligible for premium assistance. If you or your dependents are covered under the Plan, you can terminate coverage for you or your dependents during the plan year if you enroll yourself or your dependents in, and receive assistance under, CHIP or if you or your dependents become eligible for Medicaid.
To request special enrollment or obtain more information, contact the Human Resources Department at 740-687-8017.

Notice Regarding Women’s Health and Cancer Rights Act of 1998
Federal law requires a group health plan to provide coverage for the following services to an individual receiving plan benefits in connection with a mastectomy:
Reconstruction of the breast on which the mastectomy has been performed;
Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
Prosthesis and physical complications for all stages of a mastectomy, including lymph edemas (swelling associated with the removal of lymph nodes).
The group health plan must determine the manner of coverage in consultation with the attending physician and patient. Coverage for breast reconstruction and related services will be subject to deductibles and coinsurance amounts that are consistent with those that apply to other benefits under the plan.
Important Notice about Your Prescription Drug Coverage and Medicare under the Fairfield Medical Center Medical Benefit Plan ("Plan"). As the plan sponsor of the Fairfield Medical Center Medical Benefit Plan is required to provide this notice to Medical eligible employees, retirees and dependents. This notice has information regarding your current prescription drug coverage with FMC and about your options under Medicare’s prescription drug coverage. This information can help you decide whether you want to join a Medicare drug plan.

If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions regarding your prescription drug coverage is included at the end of this notice. **There are two important things you need to know regarding your current coverage and Medicare’s prescription drug coverage:** Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare prescription drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium. Fairfield Medical Center has determined that the prescription drug coverage offered by the Medical Plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

**When Can You Join A Medicare Prescription Drug Plan?**
You can join a Medicare prescription drug plan when you first become eligible for Medicare and each year from November 15 through December 31. However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two month Special Enrollment Period (SEP) to join a Medicare prescription drug plan.

**What Happens To Your Current Coverage If You Decide To Join A Medicare Prescription Drug Plan?**
If you decide to join a Medicare prescription drug plan and drop your Fairfield Medical Center prescription drug coverage, be aware that your current prescription drug coverage is part of your medical coverage from FMC. **You cannot drop your FMC prescription drug coverage unless you also drop your FMC medical coverage.** If you enroll in a Medicare Part D plan and drop your current coverage with FMC, you may not be able to return to the same plan through FMC until the next annual open enrollment period.

**When Will You Pay A Higher Premium (Penalty) To Join A Medicare Prescription Drug Plan?**
If you drop or lose your current coverage through FMC and don’t join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare prescription drug plan later. If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go 19 months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. In addition, you may wait until the following November to join.

**If you have questions about this notice or about your current prescription drug Coverage:** Contact the Human Resources at 740-687-8017. More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You” handbook. Eligible individuals will receive a copy of this handbook in the mail every year from Medicare and may also be contacted directly by Medicare prescription drug plans. **If you have questions about Medicare prescription drug coverage:** Visit www.medicare.gov; Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help; Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov or call them at 1-800-772-1213. (TTY users should call 1-800-325-0778.) **Please Note:** You will receive this notice each year. You will also receive it before the next period you can join a Medicare drug plan, and if coverage through FMC changes. You also may request a copy of this notice at any time. **Remember:** Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).