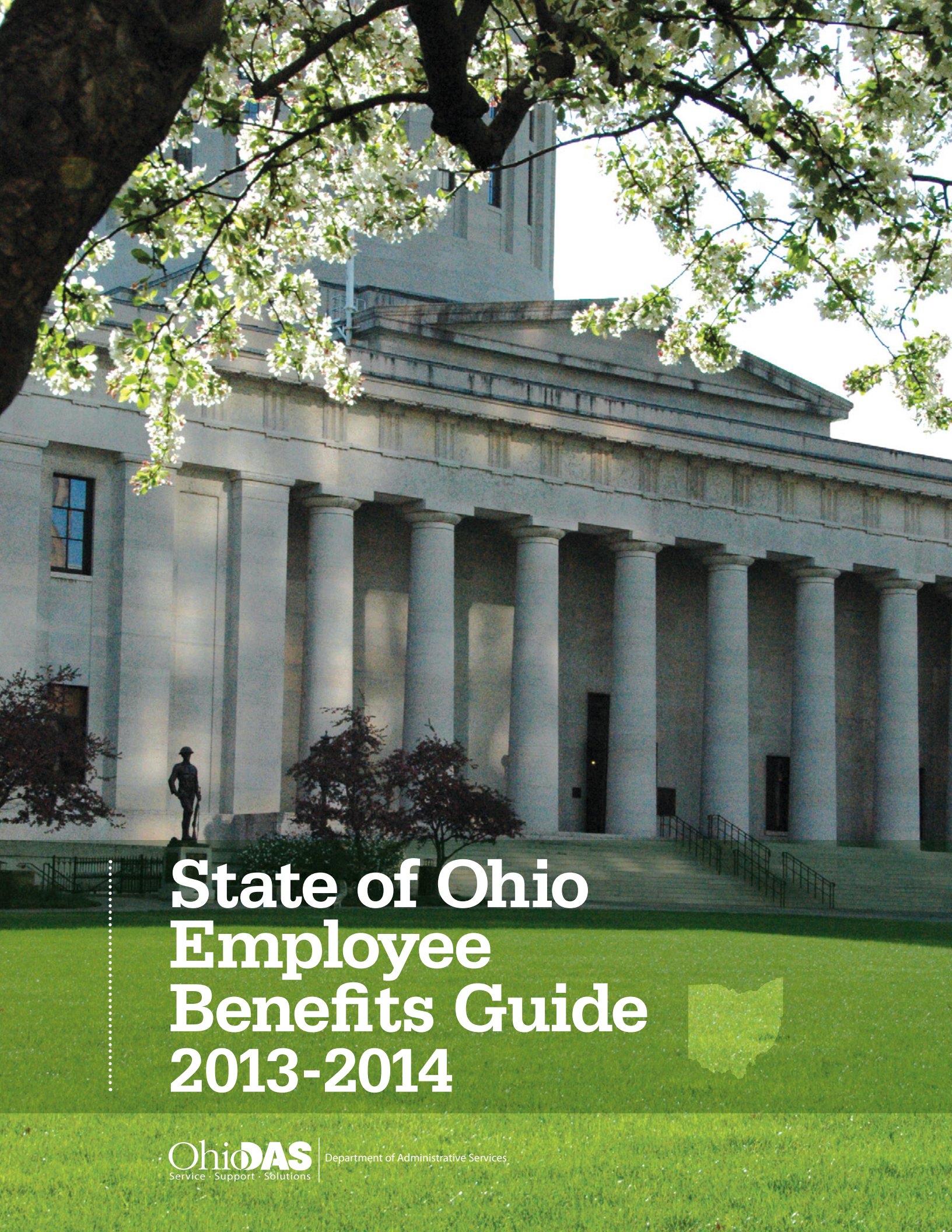

State of Ohio Employee Benefits Guide 2013-2014

OhioDAS
Service · Support · Solutions

Department of Administrative Services

Welcome to the State of Ohio

Thank you for accepting the call to public service. Employment with the State of Ohio is more than just a job – it is a privilege to serve our families, friends and neighbors who rely on us throughout our great state. You are joining a team of diligent public servants dedicated to delivering excellent, efficient services. You will play a key role in our continued success.

The compensation you receive as a State of Ohio employee includes wellness and financial benefits explained in this guide.

The benefits outlined here are effective for this benefits year, which begins July 1, 2013, and ends June 30, 2014.

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John R. Kasich
Governor
State of Ohio

Robert Blair
Director
Ohio Department of Administrative Services

The Joint Health Care Committee (JHCC)
The labor-management partnership overseeing the State of Ohio employee health care fund

CO-CHAIRS:

KELLY PHILLIPS
Co-Chair, Labor;
Ohio Civil Service Employees Association (OCSEA)

MIKE D'ARCY
Co-Chair, Management;
Ohio Department of Administrative Services

MANAGEMENT REPRESENTATIVES:

TONY BONOFIGLIO
Ohio Department of Administrative Services

TONI BROKAW-FARMER
Ohio Bureau of Workers' Compensation

KEN KIRKSEY
Ohio Department of Health, Employee Assistance Program

JIM MILLER
Ohio Department of Transportation and Ohio Department of Administrative Services

KATE NICHOLSON
Ohio Department of Administrative Services

JOAN OLIVIERI
Ohio Department of Insurance

JAN ROEDERER
Ohio Rehabilitation Services Commission

AMY SHERRETS
Ohio Department of Developmental Disabilities

ANGELA SHULL
Ohio Department of Rehabilitation and Correction

LABOR REPRESENTATIVES:

MAL COREY
State Board of Directors;
Ohio Department of Rehabilitation and Correction

DEBRA KING-HUTCHINSON
State Board of Directors;
Ohio Department of Job and Family Services

JAMES LAROCCA
State Board of Directors;
Ohio Lottery Commission

LAURA MORRIS
State Board of Directors;
Ohio Department of Health

CWA REPRESENTATIVE
MARTY BROWN BARD
Ohio Secretary of State

FRATERNAL ORDER OF POLICE
RON HAINES
Ohio Department of Natural Resources

SCOPE/OEA REPRESENTATIVE
DOMINIC MARSANO
Ohio Department of Rehabilitation and Correction

SEIU 1199 REPRESENTATIVE
BARBARA MONTGOMERY
Ohio Department of Job and Family Services

OHIO STATE TROOPERS ASSOCIATION REPRESENTATIVE
NIKKI SNEAD
Ohio Department of Public Safety

Benefits Enrollment Instructions

Review your available benefits by carefully reading this 2013 – 2014 State of Ohio Employee Benefits Guide. If you have questions, contact your agency benefits representative (or human resources office) or the Ohio Department of Administrative Services' (DAS) HR Customer Service at 1.800.409.1205 or HRcustomerservice@das.ohio.gov.

Enroll in coverage for medical, dental and vision online at: myOhio.gov or by using a paper enrollment and change form available from your agency benefits representative or online at the DAS Benefits Administration website at: das.ohio.gov/healthcareforms.

A. ONLINE

If you have not already received your Employee ID in a letter or email, please contact your agency human resources office.

If you have not obtained your password yet for myOhio.gov, please contact DAS HR Customer Service by calling toll-free, 1.800.409.1205, or in Columbus, 614.466.8857. Make sure to select Option 1 when prompted.

- Go to: myOhio.gov;
- Enter your Employee ID number and password;
- Click on **myBenefits** under Self Service Quick Access on the right side of the page;
- The Benefits Summary page will open;
- Click on **Enroll in Benefits**.

Availability

Non-Payday Week

Monday – Thursday..... Available 24 hours/day
Friday..... All day until 7 p.m.
(myPay unavailable all day)
Saturday and Sunday..... Unavailable

Payday Week

Monday – Friday..... Available 24 hours/day
Saturday..... All day except 4 to 6 p.m.
Sunday..... Unavailable

Deadline – Make and submit your selections through myOhio.gov within 31 days of your hire date. Make sure your online elections are correctly submitted. At the end of the process you will receive a confirmation message.

B. PAPER

Obtain a paper Benefit Enrollment/Change Form (ADM 4717) on the Benefits Administration website at: das.ohio.gov/healthcareforms or from your agency human resources office.

Deadline – Give your completed and signed Benefit Enrollment/Change Form (ADM 4717) to your agency human resources office within 31 days of your hire date.

Important

If you are enrolling your dependent(s) in your medical coverage, you are required to provide the required eligibility documentation for your dependents. A listing of the required documentation can be found at: das.ohio.gov/eligibilityrequirements. Coverage will not be provided for dependents until the eligibility documents are received and approved by your agency human resources office.

It will take two to four weeks from the completion of your enrollment process to receive your medical identification card. To ensure timely processing of your enrollment, please complete your enrollment and provide all necessary dependent documentation as soon as possible.

All employees must have a valid home address on file with the State of Ohio. It is the employee's responsibility to ensure the state has your current address on file. While an employee may list a P.O. box as a mailing address, an employee may not use a P.O. box as a home address.

Benefits Eligibility

The State of Ohio provides quality, affordable and competitive benefits to permanent full-time and permanent part-time employees. Great care has been taken to select plan providers to ensure you receive quality benefits at a competitive rate.

Employee Eligibility

You are eligible for the state's benefits if you are a permanent full-time or permanent part-time employee. This includes if you are an established-term regular or established-term irregular employee. Some judges and other elected and appointed officials also are eligible.

When will my coverage for each benefit begin?

Medical – Most state employees are eligible for medical coverage, including the *Take Charge! Live Well!* wellness program, prescription drug coverage and behavioral health coverage, effective the first day of the month following the month of your date of hire.

Commuter Choice Program (Qualified Transportation Benefit) – All State of Ohio employees who authorize a payroll deduction by the fifth day of each month are eligible.

Dependent Care Spending Account (Flexible Spending Account) – Permanent employees are eligible the first day of the month following their date of hire.

Health Care Spending Account (Flexible Spending Account) – Permanent employees are eligible the first day of the month following completion of their probationary period.

Supplemental Life – Exempt and union-represented employees are eligible for supplemental life insurance coverage on their date of hire and have 90 days to enroll. You must enroll directly with the carrier.

Basic Life – Exempt and union-represented employees are eligible for basic life insurance coverage after completing one full year of continuous state service. Enrollment is automatic.

Dental and Vision – Exempt and union-represented employees are eligible for dental and vision coverage effective the first day of the month after completing one full year of continuous state service. You must enroll following your anniversary date.

Disability – Full-time permanent employees who have completed one year of continuous state service and part-time permanent employees who have completed one year of continuous state service and who have worked 1,500 or more hours within the 12 calendar months preceding disability may be eligible for disability benefits.

Bargaining unit employees receive certain benefits through Benefits Trust including dental, vision, basic life and supplemental life insurance as well as the legal service plan and work/life program. For more information about these benefits, visit: benefitstrust.org/home.htm.

Dependent Eligibility

Family members described below may be eligible for coverage under your health and wellness benefits package. Documentation will be required at the time of dependent enrollment to verify eligibility. To view the detailed eligibility and documentation requirements for all dependents, please go to das.ohio.gov/eligibilityrequirements.

1. Spouse

- Your current legal spouse as recognized by Ohio law.

2. Children younger than age 26 including:

- Your biological children (married or unmarried)
- Your legally adopted children: adopted children have the same coverage as children born to you or your spouse, whether or not the adoption has been finalized. Coverage begins upon placement/custody for adoption.
- Your stepchildren
- Non-emancipated foster children
- Children for whom either you or your spouse has been appointed legal guardian
- Children for whom the plan has received a Qualified Medical Child Support order: the child must be named as your alternate recipient in the order.

Note: Dependent children are only eligible for dental and vision benefits if unmarried and younger than age 23. Dependent children ages 19 to 22 with dental and vision coverage must be students.

3. Unmarried Children Incapable of Self-Care

Unmarried children who are incapable of self-support due to mental retardation, severe mental illness or physical handicap, whose disability began before age 23 and who are primarily dependent upon you are eligible for medical coverage. When there is an unsuccessful attempt at independent living, a child covered pursuant to this provision may be re-enrolled for coverage, provided that the application is submitted within five years following loss of coverage.

CONTINUED ON PAGE 6 ▶

◀ CONTINUED FROM PAGE 5

This coverage is not automatic. You must complete the applicable form for your third-party administrator. A form for each third-party administrator can be found at: das.ohio.gov/healthcareforms.

Periodically, but not more than once a year, proof of continued incapacity and dependence must be provided upon request.

HB1 Child

Ohio House Bill 1 of the 128th General Assembly created a new category of eligibility for the state medical plan. HB1 coverage is available for medical (including prescription drug and behavioral health) coverage only.

HB1 Child requirements:

- Your unmarried child, age 26 or 27; and
- Child is your natural child, stepchild or adopted child; and
- Child is a resident of Ohio or a full-time student at an accredited public or private institution of higher education; and
- Child is not employed by an employer that offers any health benefit plan under which the child is eligible for coverage; and
- Child is not eligible for state Medicaid or federal Medicare.

A special rate applies for these children.
See the rate chart on Page 11.

You can enroll your HB1 Child with the annual Affidavit of House Bill 1 Child

If the individual has attained the age of 27 by the end of the tax year, you will be taxed on the value of the coverage for that child for the entire tax year. The state has determined the HB1 rates as the fair market value of dependent coverage. Your total medical deduction, including the deduction for your HB1 Child, will be treated as a pre-tax deduction on your paycheck. However, the HB1 rate for your age 27 HB1 child will be included in your gross income and will be subject to federal withholding and also may impact your municipal and school district income tax liability. The total amount of HB1 deductions taken for age 27 children will be reported on your Form W-2. (State of Ohio income tax is not applicable to the HB1 deduction.)

ELIGIBILITY FOR BENEFITS

DEPENDENT CATEGORY	MEDICAL	DENTAL	VISION	SUPPLEMENTAL LIFE
Children younger than age 23	Coverage available for eligible dependents[1]	Coverage available for eligible dependents[1]	Coverage available for eligible dependents[1]	Coverage available for eligible dependents
Children ages 23 - 25	Coverage available for eligible dependents[1]	No coverage available	No coverage available	Coverage available for eligible dependents
Children ages 26 - 27	Coverage available for eligible HB1 dependents[1]	No coverage available	No coverage available	No coverage available

[1] View detailed eligibility and documentation requirements at: das.ohio.gov/eligibilityrequirements.

Note: When one of your enrolled dependents is or becomes ineligible for benefits coverage based on the state's definition of eligibility, it is your responsibility to contact your agency benefits specialist (or human resources office) immediately to remove them from your coverage. Your dependent may be eligible to continue their medical, dental and/or vision benefits through COBRA (continuation coverage) if you notify your agency benefits specialist (or human resources office) within 60 days after the qualifying event. Enrollment or continuation of an ineligible dependent may result in loss of benefits, disciplinary action and/or repayment of claims.

An employee may enroll or disenroll an HB1 Child during the annual Open Enrollment period, when the child reaches the plan's limiting age or when a child experiences a change in circumstances. Examples of a change in circumstance include moving back to Ohio or the child's loss of employer-sponsored coverage. Proof of the loss of coverage is required.

Examples of persons NOT eligible for coverage as a dependent include, but are not limited to:

- A spouse from whom the employee is legally divorced or legally separated
- Children who are age 26 or older (HB1 Child coverage may be available)
- Same-sex partners
- Live-in boyfriends or girlfriends
- Parents or parents-in-law
- Grandchildren (unless the employee is the court-appointed legal guardian)
- Adults who are not the employee's or spouse's children under guardianship of employee (brother, sister, aunt, uncle, etc.)
- A spouse from a common-law marriage established after Oct. 10, 1991
- Any other members of your household who do not meet the definition of an eligible dependent

Employees are required to disenroll a dependent who becomes ineligible. Visit the Definitions and Required Documents Checklist at das.ohio.gov/eligibilityrequirements to learn what is needed to disenroll an ineligible dependent.

Providing false or misleading dependent eligibility information may result in any or all of the following actions by the State of Ohio: 1) loss of coverage; 2) disciplinary action, up to and including removal; 3) collection action to recoup payments of benefits and claims paid for individuals determined to be ineligible dependents; and/or 4) civil and/or criminal prosecution.

Did you know?

In the event of a qualifying life event, such as a marriage, divorce, birth, adoption of a child or a child reaching the age of ineligibility, you have 31 DAYS to add or remove dependents to or from coverage. If you wait longer than 31 days, you will have to wait until the next Open Enrollment period to add the dependent. If you fail to remove a dependent from coverage within 31 days of a qualifying event, you may be responsible for health care expenses incurred by the ineligible dependent.

It is your responsibility to contact your agency benefits specialist or human resources office when one of your enrolled dependents is or becomes ineligible for benefits coverage.

Medical

myOhio.gov

IN the KNOW

Medical Mutual
1.800.822.1152
medmutualstateohioemployee.com

UnitedHealthcare
1.877.440.5977 / welcometouhc.com/ohio

Prescription Drug
Catamaran
1.866.854.8850 / MyCatamaranRx.com

Behavioral Health and Substance Abuse
United Behavioral Health
1.800.852.1091 / liveandworkwell.com

Take Charge! Live Well!
Healthways
1.866.556.2288
ohio.gov/tclw

Delta Dental of Ohio
1.800.524.0149 exempt
1.877.334.5008 union-represented
deltadentaloh.com

Vision Service Plan (VSP)
1.800.877.7195 / vsp.com

EyeMed Vision Care
1.866.723.0514 union-represented

Your Medical Coverage

When you enroll in medical coverage, you automatically gain prescription drug, behavioral health and *Take Charge! Live Well!* benefits.

The Ohio Med PPO plan does not contain pre-existing condition exclusions; therefore, coverage is available to you and your eligible dependents regardless of current health or health history.

3-DIGIT ZIP CODE BREAKDOWN							
UNITEDHEALTHCARE (UHC)							
430xx	431xx	432xx	433xx	437xx	438xx	439xx	444xx
445xx	450xx	451xx	452xx	453xx	454xx	455xx	459xx
MEDICAL MUTUAL							
434xx	435xx	436xx	440xx	441xx	442xx	443xx	
446xx	447xx	448xx	449xx	456xx	457xx	458xx	

Medical coverage begins on the first day of the month following the month of your date of hire. The cost of this coverage is shared between you and your agency. You can enroll online using myOhio.gov. See the Benefits Enrollment Instructions on Page 3. You also can submit a completed State of Ohio Benefit Enrollment/Change Form (ADM 4717) to your agency human resources representative. You must complete your enrollment within 31 days of your date of hire along with required documentation. The form is available online at: das.ohio.gov/healthcareforms.

If you do not enroll within this time frame, you must wait until the annual Open Enrollment period or until you or an eligible dependent experience a change in status/qualifying event. In the event of a qualifying life event, you have 31 days to add or remove yourself or your dependents to or from coverage.

Visit the Definitions and Required Documents Checklist at: das.ohio.gov/eligibilityrequirements to learn what is needed to enroll an eligible dependent. Benefits and rate information are located on Pages 10 and 11.

The state contracts with Medical Mutual of Ohio and UnitedHealthcare to serve as the third-party administrators for the Ohio Med PPO plan. This plan allows all employees and any eligible dependents to have access to both network and non-network providers.

Medical Mutual and UnitedHealthcare each serve specific regions of Ohio based upon home ZIP codes. The administrator you will be assigned is based on the first three digits of your home ZIP code. Please review the above ZIP Code Breakdown chart by plan administrator. Employees with home ZIP codes outside Ohio will be enrolled in UnitedHealthcare.

YOUR SUMMARY OF BENEFITS AND COVERAGE

A requirement of the Affordable Care Act, the Summary of Benefits and Coverage (SBC) is a concise four-page document that details simple and consistent information about health plan benefits and coverage. It will help you to understand the basics of your coverage and allow you to compare any different coverage options you may have. It summarizes the key features of the plan, such as covered benefits, cost-sharing provisions, and limitations and exceptions. All insurance companies and group health plans must use the same standard SBC form. The SBC also contains a link to the required Uniform Glossary, which provides definitions of many commonly used health coverage and medical terms. To learn more, visit das.ohio.gov/benefits. The SBC is listed along the right navigation pane under the Publications and Notices section.

OHIO MED PPO	
OUT-OF-POCKET COSTS	
Annual Deductible	Network: $200 single, $400 family; out of network: $400 single, $800 family.
Your Copayments (Office Visits)	Network: $20; out of network: $30.
Coinsurance	Network: You pay 20%, plan pays 80%; out of network: You pay 40%, plan pays 60%.[1]
Your Out-of-Pocket Maximum	Network: $1,500 single, $3,000 family; out of network: $3,000 single, $6,000 family.[2]
BENEFIT/SERVICE	**COVERAGE LEVELS**
Chiropractic Care	• Covered at 80% in network; 60% out of network. • Unlimited visits.
Diagnostic, X-Ray and Lab Services	• Covered at 80% in network; 60% out of network.
Durable Medical Equipment	• Covered at 80% in network; 60% out of network.
Emergency Room	• Covered at 80%; $75 copay, which is waived if patient is admitted; 60% out of network for non-emergency.
Hearing Loss (Accidental, Injury or Illness)	• Covered at 80% in network; 60% out of network. • Exams and follow-ups are included in coverage. • No lifetime maximum.
Home Health Care	• Covered at 80% in network; 60% out of network; limit of 180 days.
Hospice Services	• Covered at 100% with no copay, time or dollar limitations for both in and out of network.
Immunizations	• Most are covered at 100% in network; 60% out of network.
Infertility Testing	• Covered at 80% after $20 copay, for in network; 60% after $30 copay out of network. • Coverage includes testing only.
Inpatient and Outpatient Services	• Covered at 80% in network; 60% out of network.
Maternity - Delivery	• Covered at 80% in network; 60% out of network.
Maternity - Prenatal/ Postpartum Care	• Prenatal Care: Office visits covered at 100% when billed separately from delivery; tests/procedures covered at 80% in network; 60% out of network. Postpartum Care: breast-feeding support and counseling (including lactation classes), and supplies (including breast pump rental) covered at 100%.
Physical, Occupational and Speech Therapy	• Covered at 80% in network; 60% out of network. • Unlimited visits. • Includes coverage for Autism Spectrum Disorder.
Preventive Exams & Screenings	• Most preventive care covered at 100% in network; 60% out of network. • Age restrictions may apply.
Skilled Nursing Facility	• Covered at 80%; 180-day limit, additional days covered at 60%, for both in and out of network.
Urgent Care	• $25 copay in network; $30 copay out of network. • Covered at 80% in network; 60% out of network.

[1] Plan pays 60% of Ohio Med PPO's benefit allowance and you pay any remaining balance.
[2] If your non-network charge is greater than the Ohio Med PPO allowance, your out-of-pocket costs will be more.

FULL-TIME EMPLOYEE MEDICAL DEDUCTIONS

	FULL-TIME / BIWEEKLY-PAID EMPLOYEE DEDUCTIONS[1]			FULL-TIME / MONTHLY-PAID EMPLOYEE DEDUCTIONS[1]		
	Employee Share	State Share	Total	Employee Share	State Share	Total
Single	$35.51	$200.17	$235.68	$76.95	$433.71	$510.66
Family Minus Spouse	$97.13	$549.32	$646.45	$210.45	$1,190.19	$1,400.64
Family Plus Spouse[2]	$102.90	$549.32	$652.22	$222.95	$1,190.19	$1,413.14

[1] These rates represent the total amount that will be deducted from your paycheck, including the communication surcharge.

[2] Family Plus Spouse rates above include a charge of $12.50 per month to cover a spouse.

PART-TIME EMPLOYEE MEDICAL DEDUCTIONS

	PART-TIME BIWEEKLY DEDUCTIONS[1] 75% TIER			PART-TIME BIWEEKLY DEDUCTIONS[1] 50% TIER		
	Employee Share	State Share	Total	Employee Share	State Share	Total
Single	$59.04	$176.64	$235.68	$117.84	$117.84	$235.68
Family Minus Spouse	$161.73	$484.72	$646.45	$323.22	$323.23	$646.45
Family Plus Spouse[2]	$167.50	$484.72	$652.22	$328.99	$323.23	$652.22

	PART-TIME BIWEEKLY DEDUCTIONS[1] 0% TIER		
	Employee Share	State Share	Total
Single	$235.68	$0.00	$235.68
Family Minus Spouse	$646.45	$0.00	$646.45
Family Plus Spouse[2]	$652.22	$0.00	$652.22

[1] These rates represent the total amount that will be deducted from your paycheck, including the communication surcharge.

[2] Family Plus Spouse rates above include a charge of $12.50 per month to cover a spouse.

ADDITIONAL BIWEEKLY AMOUNT FOR EACH HB1 DEPENDENT (FOR ALL ENROLLED EMPLOYEES)

	Employee Share	State Share	Total
Ohio Med PPO	$101.77	$0.00	$101.77

ADDITIONAL MONTHLY AMOUNT FOR EACH HB1 DEPENDENT (FOR ALL ENROLLED EMPLOYEES)

	Employee Share	State Share	Total
Ohio Med PPO	$220.51	$0.00	$220.51

Preventive Care

STAY HEALTHY, SAVE MONEY

Preventing and detecting disease early is important to living a healthy life. The better your health, the lower your health care costs are likely to be. One of the most important actions you can take for your health and your family's health is to schedule regular check-ups and screenings with your primary care physician.

Your State of Ohio health plan – Ohio Med PPO – offers the following services with no deductible, no copayment and no coinsurance for network providers. Other services are available for the normal copayment, coinsurance and deductible amounts.

FREE EXAMS AND SCREENINGS	
Clinical breast exam	1/plan year
Colonoscopy	Every 10 years starting at age 50
Flexible sigmoidoscopy	Every 10 years starting at age 50
Glucose	1/plan year
Gynecological Exam	1/plan year
Hemoglobin, hematocrit or CBC	1/plan year
Lipid profile or total and HDL cholesterol	1/plan year
Mammogram	1 routine and 1 medically necessary/plan year
Pre-natal office visits	As needed; based on physician's ability to code claims separately from other maternity-related services
Prostate-specific Antigen (PSA)	1/plan year starting at age 40
Stool for occult blood	1/plan year
Urinalysis	1/plan year
Well-baby, well-child exam	Various for birth to 2 years; then annual to age 21
Well-person exam (annual physical)	1/plan year

FREE IMMUNIZATIONS	
Diphtheria, tetanus, pertussis (DTap)	2/4/6/15-18 months; 4-6 years
Haemophilus influenza b (Hib)	2/4/6/12-15 months
Hepatitis A (HepA)	2 doses between 1-2 years
Hepatitis B (HepB)	Birth; 1-2 months; 6-18 months
Human Papillomavirus (HPV)	3 doses for 9-26 years
Influenza	1/plan year
Measles, mumps, rubella (MMR)	12-15 months, then at 4-6 years; adults who lack immunity
Meningococcal (MCV4)	1 dose between 11-12 years or start of high school or college
Pneumococcal	2/4/6 months; 12-15 months; annually at age 65 and older; high risk groups
Poliovirus (IPEV)	2 and 4 months; 6-18 months; 4-6 years
Rotavirus (Rota)	2/4/6 months
Tetanus, diphtheria, pertussis (Td/Tdap)	11-12 years; Td booster every 10 years, 18 and older
Varicella (Chickenpox)	12-15 months; 4-6 years; 2 doses for susceptible adults
Zoster (shingles)	1 dose for age 19 +

Note: This is not an all-inclusive list. For more information about preventive care services, please refer to: Healthcare.gov/law/about/provisions/services/lists.html.

Prescription Drug

Catamaran provides prescription drug benefits for all State of Ohio employees who are enrolled in the Ohio Med PPO plan.

PHARMACY WEBSITE OFFERS ONLINE TRACKING, TOOLS

The website for Catamaran, myCatamaranRx.com, is a private, secure website designed just for you. All of your pharmacy plan information is available at your fingertips 24/7 and kept up-to-date in real time.

Easy access to the Catamaran website allows you to:

- Compare mail-order prices and prices at local pharmacies;
- Find your lowest copay;
- Locate your pharmacy and get driving directions;
- Manage your mail-order prescriptions, including options to request a refill or track an order;
- Keep track of your health history;
- Learn more about your prescription drugs;
- Take it all with you through the Catamaran mobile app.

For questions, contact Catamaran's Pharmacy Help Desk at 1.866.854.8850.

TYPE OF MEDICATION	30-DAY SUPPLY AT RETAIL COPAYMENT	90-DAY SUPPLY AT RETAIL COPAYMENT	90-DAY SUPPLY AT MAIL-ORDER COPAYMENT
Generic	$10	$30	$25
Preferred Brand-Name	$25	$75	$62.50
Non-Preferred Brand-Name, Generic Unavailable	$50	$150	$125
Non-Preferred Brand-Name, Generic Available	$50 plus the difference between the cost of the brand-name and generic drug	$150 plus the difference between the cost of the brand-name and generic drug	$125 plus the difference between the cost of the brand-name and generic drug

The amount charged to the individual for generic, preferred brand and non-preferred brand medications will not be greater than the actual cost of the medication. Therefore, the amount charged may be less than the flat-dollar copay.

Pharmacy copays do not apply toward medical plan deductibles and the annual out-of-pocket maximum.

SPECIALTY DRUG MANAGEMENT PROGRAM

Some specialized medications for serious medical conditions such as cancer, cystic fibrosis and rheumatoid arthritis must be obtained from the specialty pharmacy through Catamaran after your first fill. Your order may be shipped to your home or workplace. A description of the program and a list of specialty medications may be found on the Benefits Administration website at: das.ohio.gov/prescriptiondrug under "Important Prescription Drug Updates."

NOT ALL DRUGS ARE COVERED

Some drugs require the use of alternative medications before being approved. This is known as "step therapy." Examples include medications used for heartburn, glaucoma, multiple sclerosis, diabetes, asthma, elevated triglycerides, migraines, osteoporosis, nasal allergies, sleep disturbances and high blood pressure as well as atypical antipsychotics and antiviral medications such as Valtrex®. Additional medications requiring step therapy may be added at any time. If this occurs, members currently using the affected drugs will be notified by mail.

A description of the program and a list of medications are on the Benefits Administration website at: das.ohio.gov/prescriptiondrug under "Important Prescription Drug Updates."

Nutritional supplements and specialized baby formulas are not a covered benefit.

Behavioral Health

HELP AVAILABLE 24/7

Specialized mental health and chemical dependency services are provided under a single program available to all employees and dependents enrolled in the state's medical plan. This program, administered by United Behavioral Health (UBH) and also known as OptumHealth Behavioral Solutions, provides 24-hours-a-day, seven-days-a-week phone assessment and referral services for a variety of behavioral health issues, such as:

- Depression
- Stress
- Serious mental illnesses
- Marital and family issues
- Alcohol and drug dependency
- Anxiety

In addition, habilitative services are available to members with a medical diagnosis of Autism Spectrum Disorder, which include:

- Clinical Therapeutic Intervention administered by or under the supervision of a qualified/approved provider, in accordance with an approved applied behavioral analysis (ABA) treatment plan, for up to 20 hours per week. (An hour is defined as each hour billed by the provider. For example, if two specialists are providing service for one hour, it would be calculated as two hours.)
- Mental/Behavioral Health outpatient services performed by a psychologist, psychiatrist, physician or board-certified behavior analyst who is a licensed/qualified/approved provider for consultation/assessment/development/oversight of treatment plans.
  - ABA services must be pre-certified. Treatment that is not pre-certified may result in no coverage.
  - ABA services are limited to 20 hours per week, including services provided for a consultation/assessment/development/oversight of ABA treatment plans.

Copayments, deductibles and coinsurance are shared and combined with your medical plan. If you receive mental health services prior to meeting your medical plan deductible, you may need to pay for these services up to the deductible amount before your plan starts paying. This does not apply to routine office visits for which you only pay an office visit copayment.

BENEFITS

All enrolled employees and their families have access to both in-network and out-of-network behavioral health benefits. However, you will pay more if you do not use UBH-participating providers and facilities. See the chart on this page for more information.

BEHAVIORAL HEALTH BENEFIT PLAN	
Copayments	
Outpatient office visit in-network	$20
Outpatient office visit out-of-network	$30; Balance billing applies
Emergency Room	$75
Intensive outpatient care in-network	$20
Intensive outpatient care out-of-network	$30; Balance billing applies
Deductibles	
Single in-network	$200 combined with medical
Family in-network	$400 combined with medical
Single out-of-network	$400 combined with medical
Family out-of-network	$800 combined with medical
Plan Coinsurance %	
Outpatient in-network	100% after office visit copay; 80% for other services
Outpatient out-of-network	60% of fee schedule after copayment; Balance billing applies
Inpatient in-network	80% after deductible; $350 penalty if not preauthorized
Inpatient out-of-network	60% after deductible; $350 penalty if not preauthorized
Out-Of-Pocket Maximum	
Single in-network	$1,500 combined with medical
Family in-network	$3,000 combined with medical
Single out-of-network	$3,000 combined with medical
Family out-of-network	$6,000 combined with medical
Other	
Day Limits	None
Annual Limits	None
Lifetime Limits	None
Benefits Limits	Some

Wellness Program

IMPROVE YOUR HEALTH ONE STEP AT A TIME

More and more, employees are looking to change their lifestyle in an effort to improve their long-term health. Dieting and setting short-term fitness goals, such as running a 5K race, are worthwhile and can help you improve your health. However, adopting a healthier lifestyle can help you maintain good health.

Take Charge! Live Well! – the health and wellness program for state employees and spouses enrolled in the State of Ohio health plan – offers tools for you to enhance your wellness experience and help you achieve your wellness goals.

Start by completing your biometric screening* and your Well-Being Assessment*. Then choose your pathway – either the Online Pathway or the Coaching Pathway – and you are on your way to a healthier lifestyle.

The chart to the right describes how easy it is to take the necessary steps toward improving your health and the incentives for achieving milestones. State employees and spouses enrolled in the State of Ohio health plan are each eligible to receive up to $350 in incentives.

*Terms are defined in the Glossary on Page 27.

EARN GIFT CARDS

After completing an activity that merits an incentive, you will have the option to choose your incentive gift card(s) from many national brands. For a list of available gift cards, visit ohio.gov/tclw, click on the **Healthways Website** button, log in and click on the **Rewards Center** tab.

In addition, you will be able to request to receive your gift card immediately after completing each incented activity or accumulate incentive payments for a larger payout after completing multiple incentive activities. Some gift cards, like iTunes, are even available through email.

In your effort to become healthier, *Take Charge! Live Well!* will be there for you. Make today a new day for a new you!

PATHWAYS TO WELLNESS

Step 1: ASSESS YOUR HEALTH

- Complete your biometric screening through an on-site screening or through your physician: **Earn $75**
- Complete your Well-Being Assessment: **Earn $50**

  BONUS: Submit BOTH by Nov. 30, 2013: **Earn another $25**

Step 2: TAKE ACTION – It's Your Choice! Earn $200

COACHING PATHWAY

Prerequisite: Well-Being Assessment and biometric screening must be completed before earning an incentive for the Coaching Pathway.

- Complete four telephonic coaching sessions.

----- OR -----

ONLINE PATHWAY

Prerequisite: Well-Being Assessment must be completed prior to starting your Online Pathway.

1. Complete your online Well-Being Plan.
2. Choose five of the nine online tools to help you achieve your wellness goals. Each of the five online tools you choose must be completed 10 times.
   - Exercise Tracker – update your Exercise Tracker.
   - Food Tracker – update your Food Tracker.
   - Servings Tracker – update your Servings Tracker.
   - Body Weight Tracker – update your Body Weight Tracker.
   - Steps Tracker – update your Steps Tracker.
   - Medication Tracker – update your Medication Tracker.
   - View/Read/Listen Resources – view online videos or read online stories.
   - Journal Entry – update your personal wellness journal.
   - Complete Action Item – complete an action item assigned within a certain focus area or by a personal health coach.

Reward cards are considered taxable compensation. The taxes on the amount of your incentive will be deducted from your paycheck.

For more detailed information about incentives, go to the *Take Charge! Live Well!* website at ohio.gov/tclw and click on the **Incentive Guide** button.

Diabetes Prevention Program

THE PROGRAM THAT HELPS PREVENT OR DELAY TYPE 2 DIABETES

If you enroll in UnitedHealthcare, this program is available at no additional cost as part of your health insurance plan.

PROGRAM HIGHLIGHTS

The Diabetes Prevention Program includes:

- 16 lifestyle coaching group sessions
- Nutrition counseling
- Private weekly weigh-ins
- Detailed program handbook
- Convenient locations
- Follow-up monthly maintenance
- Specially trained coaches

GROUP SETTING

You are not alone. Group support helps participants feel inspired and stay motivated. Together, you can learn how to successfully adopt healthy new behaviors.

TRAINED LEADERS

Specially trained coaches lead the small group sessions and work closely with participants for active problem-solving and individual goal-setting.

GET THE RESOURCES, TOOLS AND MOTIVATION YOU NEED TO SUCCEED

In 16 sessions, you will cover a wide range of topics including: Tipping the Calorie Balance, Four Ways to Healthy Eating Out, Ways to Stay Motivated and much more.

NOT ME

To determine your eligibility, enroll or find a local class and screening events near you, call the Diabetes Prevention and Control Alliance (DPCA) at 1.800.650.2885 and say "NOT ME." Find more information on the *Take Charge! Live Well!* website at: ohio.gov/tclw.

DIABETES MANAGEMENT PROGRAM

Employees and their dependents who participate in the *Take Charge! Live Well!* program may be eligible for free diabetic supplies and medication if they have had a Hemoglobin A1c test in the past 12 months. To learn if you qualify for this benefit, contact Healthways at 1.866.556.2288.

FOR EXEMPT EMPLOYEES

Dental and Vision

The state pays the cost for exempt employees and their eligible dependents (children younger than age 23) to participate in the dental and vision plans. Employees are eligible to participate in these programs after one year of continuous state service.

An enrollment packet will be mailed to you prior to your one-year anniversary. Coverage will be effective the first day of your 13th month of state service, as long as you submit your completed enrollment form at least 31 days before your anniversary date. You may enroll in dental and vision coverage up to 31 days after your anniversary date, but your effective date of benefits may be delayed. If you do not enroll within 31 days of your anniversary date, you must wait until the next open enrollment period or when you have a qualifying event to obtain dental and/or vision care coverage.

Delta Dental Plan

Dental coverage is offered to eligible exempt employees and their dependents through the Delta Dental PPO plan, offered through Delta Dental of Ohio. The Delta Dental PPO plan provides employees with access to two networks of dentists – the Delta Dental PPO network and the Delta Dental Premier network. In addition, you can go to any licensed dentist of your choice and receive benefits. However, you will generally pay less when you go to a dentist within the Delta Dental PPO or Delta Dental Premier network. For most covered services, Delta Dental pays a higher percentage if you go to a dentist in its PPO network over its Premier network. Delta Dental pays the least for out-of-network dentists. Check with your dentist to determine whether he or she belongs to the Delta Dental PPO or Delta Dental Premier network.

To find the names of participating Delta Dental dentists near you, visit or call:

deltadentaloh.com
1.800.524.0149
Group Number: 9273-0001

First-time users to deltadentaloh.com: Log in using your Employee ID number and date of birth.

PRINT YOUR DELTA DENTAL CARD ONLINE

If you would like a card to present to your dentist, you may print a card from Delta Dental's website. After you are enrolled in the dental plan, visit: deltadentaloh.com and click on **Consumer Toolkit**. Complete the login process and click on **Print ID Card**.

Vision Service Plan (VSP)

Vision coverage is offered to eligible exempt employees and their dependents through Vision Service Plan (VSP). The VSP Choice network encompasses a large number of providers. If you choose to use a non-network provider, out-of-network charges will apply.

To find the names of participating VSP vision providers near you, visit or call:

vsp.com
1.800.877.7195
Group Number: 12022518

PRINT YOUR VSP CARD ONLINE

If you would like an enrollment card to present to your vision provider, you may print a card through the VSP website. After you are enrolled in the vision plan, visit vsp.com, complete the login process and click on the **My Member Vision Card**.

See the next page to view the in-network and out-of-network benefits for the dental and vision plans.

FOR UNION-REPRESENTED EMPLOYEES

Union-represented employees receive dental, vision, life and legal plan benefits through Union Benefits Trust (UBT). For more information about these benefits, visit benefitstrust.org/home.htm.

DELTA DENTAL PLAN
for exempt employees

	Delta Dental PPO Dentist	Delta Dental Premier Dentist	Non-Delta Dental Dentist*
Annual Maximum	$1,500	$1,500	$1,500*
Diagnostic & Preventive Services	100%	100%	100%*
Basic Restorative Services (e.g., fillings)	100%	65%	65%*
Major Restorative Services (e.g., crowns, bridges)	60%	50%	50%*
Orthodontia	50% up to $1,500 lifetime maximum	50% up to $1,500 lifetime maximum	50% up to $1,500* lifetime maximum

Deductible – $25 deductible per person total per benefit year. The deductible does not apply to diagnostic and preventive services, emergency palliative treatment, X-rays, periodontal maintenance (cleaning) and orthodontic services.

There is a separate $1,000 lifetime maximum on dental implants.

*Delta Dental will pay up to the allowed amount or the maximum allowable charge for providers in your area. You can be balance billed by non-Delta Dental providers for any amount that exceeds the allowable amount. Network providers cannot balance bill you for the difference between their charge and Delta Dental's allowed amount.

VISION SERVICE PLAN (VSP)
for exempt employees

Service	In-Network	Out-Of-Network
Routine Exam/Frame/ Lens Frequency	1 every 12 months	
Routine Exam/ Professional Fees	Plan pays 100% after $10 copay.	You pay $10 copay, then plan pays maximum of $25.
MATERIALS/LENSES Single Vision Lenses Bifocal Lenses Progressive Lenses Trifocal Lenses Lenticular Lenses Polycarbonate Lenses	Plan pays 100% after $15 copay.	You pay $15 copay, then plan pays maximum benefit of: $25 $35 $52 $52 $62 $0
FRAMES	Plan pays 100% up to $120 retail.	Plan pays maximum benefit of $18.
CONTACT LENSES Elective (Instead of Lenses & Frames)	Plan pays maximum of $125 plus standard eye exam. Plan pays 100% plus standard eye exam.	
Medically Necessary	Plan pays 100% plus standard eye exam.	Plan pays maximum of $125 plus standard eye exam.

Financial Security

Ohio.gov

IN the KNOW

Basic and Supplemental Life Insurance
Minnesota Life
866.293.6047
lifebenefits.com

Financial Security

Forecasting future financial needs can be challenging. Whether you are attempting to assess retirement goals or ensure that your family is provided for in the event that the unanticipated happens, we understand your financial security is an especially important concern. The insurance programs available through the State of Ohio offer steady sources of income and can be tailored to your specific needs.

All policy benefits are subject to limitations and restrictions. Visit das.ohio.gov/benefits for more information about:

- Basic Life Insurance
- Supplemental Life Insurance
- Disability Insurance
- Workers' Compensation

Union-represented employees may visit: benefitstrust.org or see Page 38 for basic and supplemental life insurance contact information.

EXEMPT BASIC LIFE INSURANCE

The State of Ohio provides basic life insurance coverage through Minnesota Life, including an accidental death and dismemberment benefit for work-related injuries, to all eligible exempt employees who have one year of continuous state service. This benefit – equal to one times your annualized rate of pay rounded up to the next highest $1,000 – is provided at no cost to you.

The IRS requires that employees be taxed on the value of employer-paid group life insurance coverage exceeding $50,000. This is known as "imputed income." If your annualized rate of pay (and thus your group life insurance) exceeds $50,000 per year, the tax you owe on the value of the coverage that exceeds $50,000 is reported to the IRS in Box 12 of your year-end W-2 form. The tax is based upon employee age brackets on the last day of the calendar year and increases in five-year increments as you grow older. See Page 21 for the imputed income rate chart.

EXEMPT SUPPLEMENTAL LIFE INSURANCE

Exempt employees are eligible to purchase supplemental life insurance coverage, provided by Minnesota Life. This coverage is at your own cost, and can be purchased immediately upon employment with no waiting period. When you enroll for the coverage, you also may elect life insurance for your eligible dependents. The amount you contribute toward your supplemental and dependent life coverage is deducted from your paycheck. See Page 38 for plan contact information.

For Yourself

You may enroll for Supplemental Life Insurance Coverage on your date of hire. You have 90 days to enroll. You can enroll up to eight times your annualized earnings, rounded to the next higher $10,000, not to exceed $600,000. You must provide evidence of insurability if you request an amount of insurance over the non-medical limit for new hires – the lesser of three times your annualized earnings or $500,000. Coverage below the non-medical limit amount will be effective the first of the month after your first supplemental life payroll deduction. Coverage above the non-medical amount, which is subject to evidence of insurability, will be effective the first of the month after your evidence of insurability has been approved.

For Your Spouse

You can purchase supplemental life insurance for your spouse in $10,000 increments up to $40,000. Spousal coverage in excess of $10,000 requires your spouse to provide evidence of insurability.

For Your Dependent Children

You may purchase $7,000 of life coverage for each of your eligible dependent children younger than age 26 at a rate of $0.82 cents per month regardless of how many children you cover. You are responsible for dropping your dependent's coverage when your child reaches age 26.

How to Enroll in Supplemental Life

To enroll in supplemental life coverage, visit the Minnesota Life website at www.lifebenefits.com. You also may obtain a supplemental life enrollment form on the Benefits Administration website Forms page at: das.ohio.gov/healthplanforms.

Should you have questions regarding supplemental life insurance, please contact Minnesota Life and provide group number 34301. See the Contacts section on Page 38 for more information.

BENEFICIARY FORMS

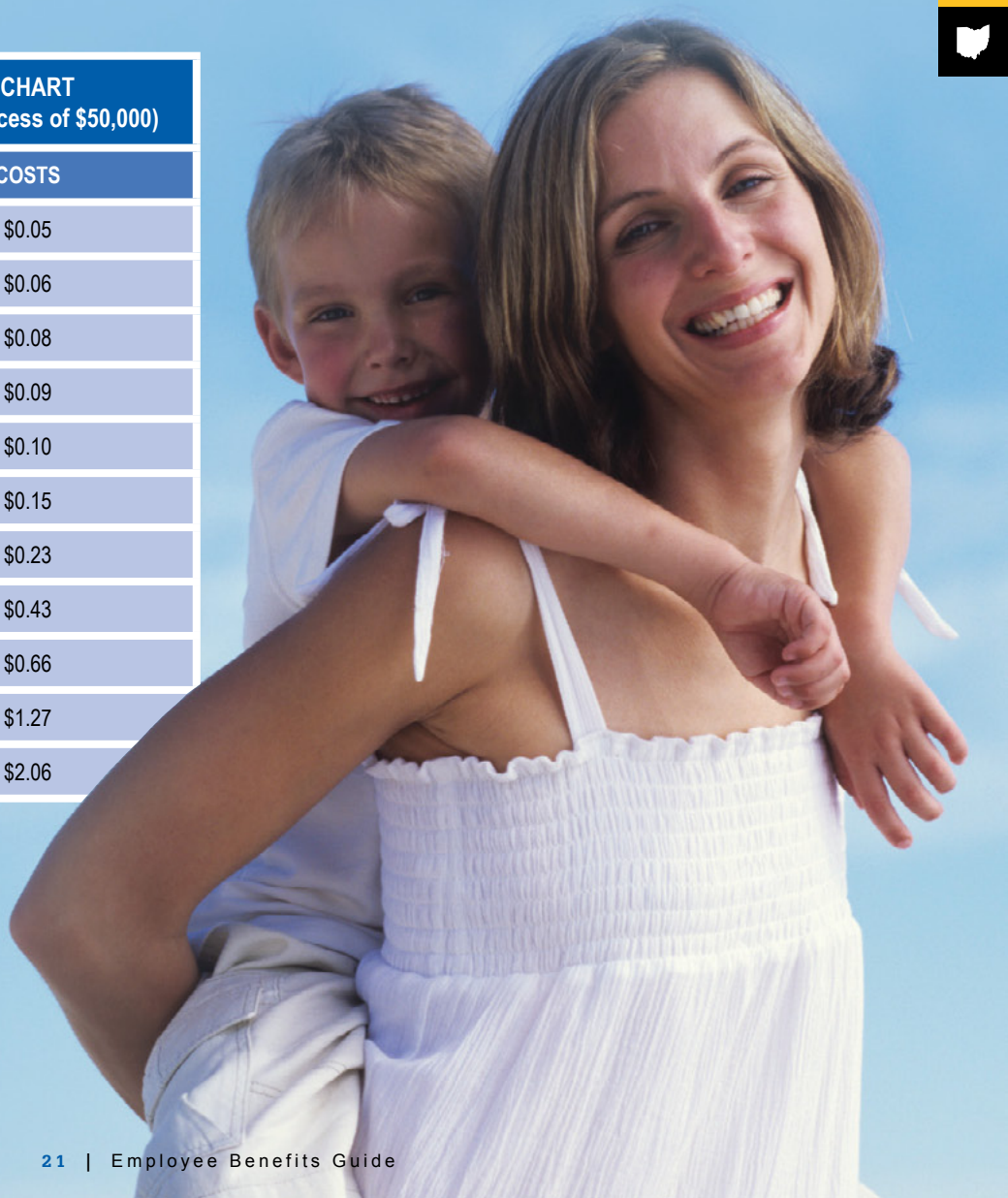
(Exempt Basic and Supplemental Life Insurance)

You may designate one or more beneficiaries for your basic and supplemental life benefits by visiting the Minnesota Life website at www.lifebenefits.com. Alternatively, you may submit a beneficiary form by mail to Minnesota Life. This form also is available in the forms section of the Benefits Administration website, located at: das.ohio.gov/healthplanforms.

Please note that your beneficiary elections will apply to both your basic and supplemental life insurance benefits.

IRS BASIC LIFE IMPUTED INCOME CHART (Monthly Cost Per $1,000 of Coverage in Excess of $50,000)

AGE	COSTS
Younger than 25	$0.05
25 through 29	$0.06
30 through 34	$0.08
35 through 39	$0.09
40 through 44	$0.10
45 through 49	$0.15
50 through 54	$0.23
55 through 59	$0.43
60 through 64	$0.66
65 through 69	$1.27
70 and older	$2.06



DISABILITY BENEFITS

As a State of Ohio employee, you are eligible to apply for disability leave benefits. These medical benefits provide financial and emotional assistance to you and your family in the event that you are unable to perform the duties of your position due to a non-work-related disabling illness, injury or condition for a period of more than 14* consecutive calendar days.

Disability Eligibility

Those who may be eligible for disability benefits include:

- Any full-time permanent employee with a disabling illness, injury or condition that will last more than 14 consecutive calendar days and who has completed one year of continuous state service immediately prior to the date of the disability.
- Part-time employees who have completed one year of continuous state service and who have worked 1,500 or more hours within the 12 calendar months preceding disability.

What conditions are covered?

The following disabling illnesses, injuries or conditions may be considered for disability leave benefits:

- Non-work-related injury or illness
- Mental health conditions
- Substance abuse conditions
  (An employee must be receiving ongoing treatment, which prevents the employee from working.)

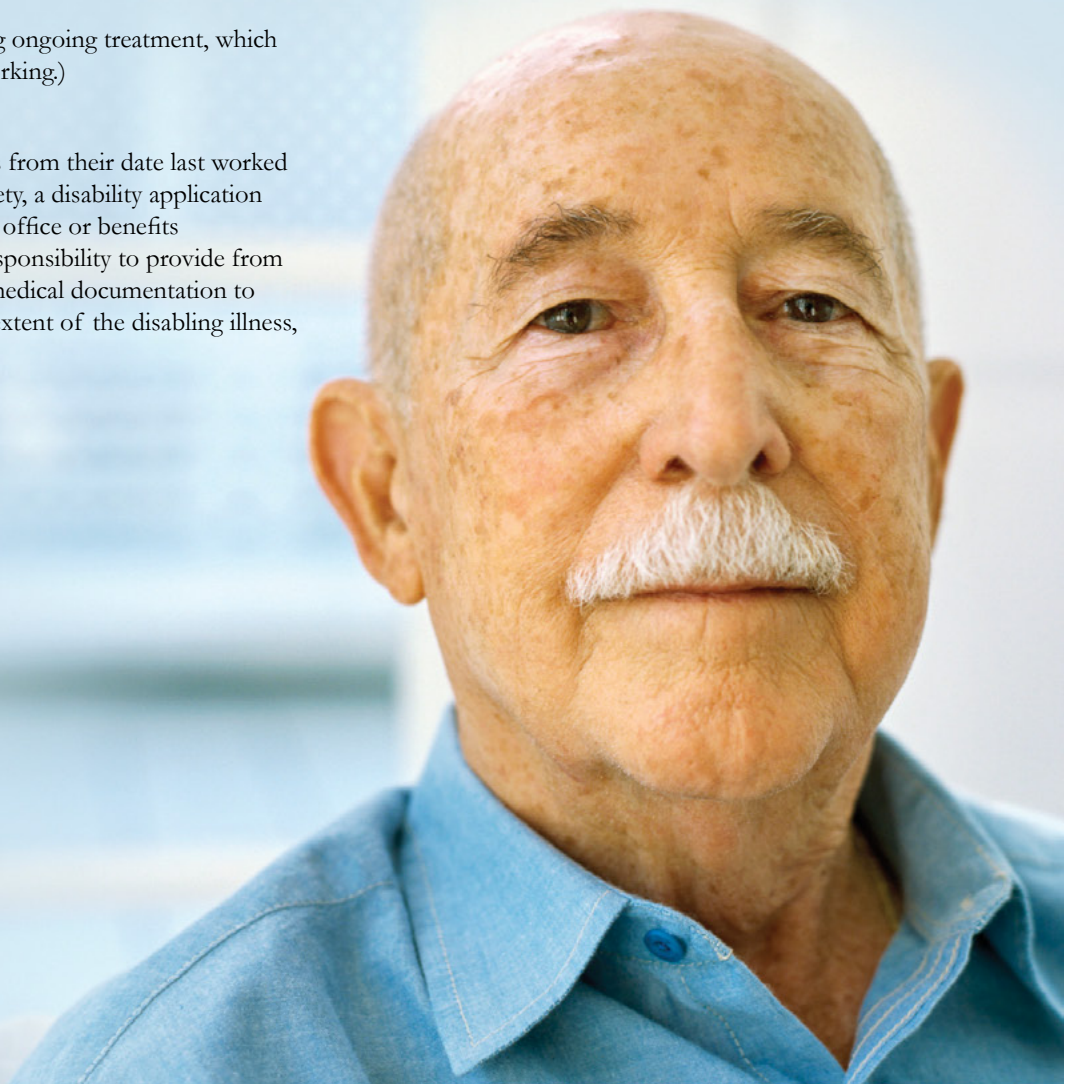
How to apply

An employee has 20* calendar days from their date last worked to obtain and complete, in its entirety, a disability application with their agency human resources office or benefits coordinator. It is the employee's responsibility to provide from their respective treating source(s) medical documentation to substantiate the cause, nature and extent of the disabling illness, injury or condition.

Payment while on disability leave

As a State of Ohio employee, there is no cost to you for disability leave benefits. Each state agency pays a percentage of its payroll into the disability fund. Disability benefits are paid at 67 percent of the employee's base rate of pay subject to a lifetime maximum of 12 months of eligibility* (whether the employee files a new, subsequent-related or subsequent-unrelated claim). The employer's and employee's share of the health, life and other insurance benefits will be paid by the employer during the period the employee is pending and receiving disability leave benefits. The employee will be responsible for paying their portion of retirement contributions.

* Employees of the Auditor of State, Ohio Attorney General, Secretary of State and Treasurer of State subject to a collective bargaining agreement should refer to the applicable contract.



WORKERS' COMPENSATION

Workers' compensation is a 'no-fault' system that compensates employees for work-related injuries or illnesses.

When an Injury Occurs

- Reporting: follow your agency's policy on reporting incidents and injuries.
- Obtain medical care promptly. If you wish to request salary continuation or occupational injury leave, you must use an approved Workplace Injury Labor Management Approved Provider Committee (WILMAPC) provider. To locate an approved WILMAPC provider, go to: www.das.ohio.gov/Divisions/CollectiveBargaining/Wilmapc/tabid/479/Default.aspx or your managed care organization (MCO) can provide you with names of approved providers in your area. Failure to adhere to your agency reporting guidelines or policy when applying for salary continuation or occupational injury leave may result in denial of benefits. If emergency treatment is required, go immediately to the nearest emergency facility and follow up with an approved provider to obtain benefits.
- Complete an Accident or Illness Report (ADM 4303).

Employer-Provided Benefits for Workers' Compensation Claims

Salary Continuation

- Provides the injured employee with 100 percent of his/her regular rate of pay in lieu of workers' compensation temporary total benefits if an approved WILMAPC provider is used.
- Benefits are not to exceed 480 hours.
- This benefit is available to permanent full-time or part-time employees. The Offices of the Auditor of State, Attorney General and Secretary of State do not participate in salary continuation. Also, employees covered by the Ohio State Troopers Association collective bargaining agreement are not eligible for salary continuation.
- Once salary continuation benefits are exhausted, you may be eligible to receive lost time benefits from the Ohio Bureau of Workers' Compensation (BWC). You and your attending physician will need to file a Request for Temporary Total Compensation (Form C-84).
- Payments for salary continuation are included in your bi-weekly pay.
- Filing a Claim:
  - File an Accident or Illness Report using the ADM 4303 form.
  - Follow your agency's accident reporting guidelines.
  - File a workers' compensation claim within 20 calendar days from the date of the injury.
  - Receive treatment from an "approved physician" on the approved WILMAPC provider panel.
  - Submit supportive medical information by having your physician complete the BWC form, MEDCO 14 Physician's Report of Work Ability.

CONTINUED ON PAGE 24 ▶

◀ CONTINUED FROM PAGE 23

Occupational Injury Leave

- Provides the injured employee with 100 percent of his/her regular rate of pay in lieu of workers' compensation benefits if an approved WILMAPC provider is used.
- Benefits are limited to a maximum number of hours determined by your bargaining unit. Non-bargaining unit employees have a maximum of 960 hours.
- This benefit is available to employees who are injured in the line of duty as a result of a bodily injury sustained by an inmate, client, patient, resident, youth or student, and is limited to specific agencies. You may contact your benefits representative or refer to your union contract for specific information.
- Once occupational injury leave benefits are exhausted, you may be eligible to receive lost time benefits from BWC. You and your attending physician will need to file a Request for Temporary Total Compensation (Form C-84).
- Bargaining unit employees may appeal a denied occupational injury leave decision and should refer to the appeal procedure in their union contract.
- Appeals should be sent to the DAS Office of Collective Bargaining within 20 days of the denial.
- Exempt employees may appeal a denied occupational injury leave decision by completing the Occupational Injury Leave Appeal Form located on the Benefits Administration website at: das.ohio.gov/healthcareforms. Instructions are located on the form. For exempt employees, the decision by Benefits Administration is final.
- Payments for occupational injury leave are included in your biweekly pay.

- Filing a Claim:
  - File an Accident or Illness Report using the ADM 4303 form.
  - Follow your agency's accident reporting guidelines.
  - File a workers' compensation claim within 20 calendar days from the date of the injury.
  - Receive treatment from an "approved physician" on the approved WILMAPC provider panel.
  - Submit supportive medical information by having your physician complete the BWC form, MEDCO 14 Physician's Report of Work Ability.

Disability Advancement

Disability advancement is a monetary advancement of disability benefits that an injured worker can receive while awaiting approval of his or her workers' compensation claim.

- This advancement is available only if the BWC denies your initial claim for workers' compensation benefits and you are appealing the decision. If you do not intend to appeal, you may file for disability benefits within 20 days of the denial order.
- You may receive the advancement for a maximum of 12 weeks. If your workers' compensation claim is approved through the appeal process or by a settlement, you will be required to pay back all of the money that has been advanced, regardless of the amount received from BWC or the settlement.
- To file for disability advancement, complete the disability application and disability agreement. Submit them with your denial order to your human resources office within 20 days of the notification of denial.

Leave Buy Back

Some bargaining unit employees have the option of buying back leave time that was used while waiting for a workers' compensation claim to be approved. See your bargaining unit contract to determine your eligibility.

A wage advancement agreement is a contract between you and your employer that states the amount of leave time that you will buy back.

You may buy leave time back either with or without a wage advancement agreement.

LONG-TERM CARE COVERAGE

Prudential to Service Current Enrolled Policyholders Only

The Prudential Insurance Company of America discontinued sales of group long-term care insurance products, including the State of Ohio Long-Term Care Plan, to new enrollments as of July 1, 2013.

Prudential will continue to cover participants enrolled in the program as long as premiums are paid on time and benefits are not exhausted. Coverage is guaranteed renewable. Your rate is guaranteed not to increase through June 30, 2015. Premiums may change in the future, on a class basis, subject to regulatory review. Existing policyholders will continue to receive inflation offers and will have the ability to decrease coverage at any time. In addition, you have no obligation to continue the benefit and may cancel at any time.

Flexible Spending Accounts

myOhio.gov

IN the KNOW

Flexible Spending Accounts and Commuter Choice
WageWorks
1.855.428.0446
www.wageworks.com

Flexible Spending Accounts

Health Care Spending Account

The health care spending account (HCSA) is a tax-favored account that provides the opportunity for eligible employees to defer on a pre-tax basis up to a maximum of $2,500 into an account to pay for eligible medical expenses not paid by your health care, vision or dental plans. There is no administrative fee for participants. The WageWorks Health Care Card, a payment card that facilitates payment of eligible health care expenses, is issued to all participating employees and can be requested for eligible dependents.

For more detailed information about eligible expenses, the HCSA or the payment card, visit the WageWorks website, wageworks.com. WageWorks, Inc. is the vendor for the State of Ohio's Flexible Spending Accounts program.

Dependent Care Spending Account

The dependent care spending account (DCSA) is a tax-favored account that provides the opportunity for eligible employees to defer on a pre-tax basis up to a maximum of $5,000 (depending on tax status) into an account to pay for eligible child care, dependent care and eldercare expenses. For more detailed information about the DCSA, please visit: wageworks.com, the website for the State of Ohio's program vendor, WageWorks.

Enrollment Eligibility

Health Care Spending Account (HCSA)

To enroll in an HCSA, you must:

- Be a permanent part-time or permanent full-time employee with sufficient pay to cover the election amount; and
- Enroll within 30 days of the hire date, if there is no probationary period; or
- Enroll within 30 days of completing probation, if there is a probationary period.

It is not necessary to be enrolled in the State of Ohio's health benefits to participate in the HCSA. If both a husband and wife are state employees, both may participate in the HCSA as separate individuals.

Dependent Care Spending Account (DCSA)

To enroll in a DCSA, you must:

- Be a permanent part-time or permanent full-time employee with sufficient pay to cover the election amount;
- Have a qualifying dependent(s); and
- Enroll within 30 days of the hire date.

Both a husband and wife, regardless if they are state employees, may participate in the DCSA as separate individuals but cannot exceed the $5,000 IRS maximum per family.

If an employee does not enroll within the time frames noted, other opportunities to enroll are as follows:

- During the annual open enrollment period
- Following a change in status: According to the IRS regulations governing Section 125 Cafeteria Plans, a mid-year change can be made to the employee's HCSA and DCSA election. However, the proposed change must be consistent with the type of change experienced. Contributions and benefit changes must be an appropriate result of the change in status. The time frame for notification is within 30 days of the qualifying event.

For more detailed information about Flexible Spending Accounts, please visit: das.ohio.gov/flexiblespendingaccount or the WageWorks website at: wageworks.com.

IRS Forfeiture Rule

Federal regulations require that at the end of the calendar year, or at the end of the month of your employment termination, any unspent HCSA or DCSA balance will be forfeited.

Commuter Choice Parking and Transit Program

The Commuter Choice program covers two types of commuting expenses:

- Transportation expenses, which include qualified fares for riding buses, trains, subways, ferries and other types of mass transportation or van pools.
- Parking expenses which include the cost of parking at or near your place of work or at or near a place from which you commute to work by mass transit, such as a park-and-ride lot.

When you enroll in Commuter Choice for eligible transportation expenses, you are authorizing the third-party administrator, WageWorks, to purchase your public transportation fare passes (e.g., bus pass) and van pool passes, directly from your transportation provider.

Visit: das.ohio.gov/commuterchoice for more information.

The 2013 IRS monthly allowable dollar limit for transit is $245. When you enroll for the Commuter Choice transit benefit, the fare pass will be delivered directly to your home address.

The 2013 IRS monthly allowable dollar limit for parking is $245. When you enroll for the Commuter Choice parking benefit, WageWorks will pay your parking service directly.

Should your parking and/or transit expenses exceed the IRS monthly allowable dollar limit, you may have additional dollars withheld on an after-tax basis to pay your expenses that exceed the IRS dollar limit.

Administrative Fees

The monthly administrative fee for parking and transit is $4.89 on an after-tax basis.

GLOSSARY

When reviewing information about your health care coverage options, it's helpful to understand some of the basic terms and concepts.

Benefit Year/Plan Year: The 12-month period from July 1 through June 30 during which services are rendered, and your deductible and coinsurance are accumulated.

Biometric Screening: A private screening with a health professional that provides a snapshot of your health. The screening includes cholesterol (total), HDL, LDL, blood glucose, blood pressure, height, weight and waist circumference.

Coinsurance: The percentage of eligible expenses that the health care plan pays after the annual deductible is met. For example, an 80 percent coinsurance rate means you pay 20 percent and the plan pays 80 percent.

Copay: A specified dollar amount you pay to a health care provider or pharmacy for eligible expenses such as office visits and prescriptions. Copays do not count toward your annual deductible.

Deductible: The amount you pay for eligible expenses each plan year before the plan begins to pay anything.

Eligible Expense: The maximum amount on which payment is based for covered health care services. You may be required to pay a percentage of Eligible Expenses in the form of Coinsurance.

Employee Contribution: The portion of the total premium that you pay through pre-tax payroll deductions for your insurance coverage.

Exempt Employee: An appointment to a position not represented by a labor union. Employees are usually exempt from union representation because they are supervisors, in positions of a confidential or fiduciary nature, or not in permanent appointments.

Flexible Spending Account: A type of savings account that provides the account holder with specific tax advantages. The account allows employees to contribute a portion of his or her regular earnings to pay for qualified expenses, such as medical expenses or dependent care expenses.

House Bill 1 (HB 1): Ohio House Bill 1 of the 128th General Assembly created a new category of eligibility for the state medical plan. Medical coverage (including prescription drug and behavioral health benefits) is available to overage children up to age 28 only. A special rate applies for these children. Please refer to: das.ohio.gov/eligibilityrequirements for eligibility requirements.

Out-of-pocket Maximum: The cap or maximum amount you pay for eligible out-of-pocket health care expenses during the plan year. After your out-of-pocket expenses reach the maximum, the plan pays 100 percent of any additional eligible expenses for the remainder of the plan year. Prescription copays do not apply to the out-of-pocket maximum.

Preferred Provider Organization (PPO): When you enroll in the Ohio Med PPO, you may visit any doctor and receive benefits. However, the benefit is less when you use providers who are not part of the PPO network. Ohio Med is available to all employees eligible for medical care.

State Contribution: The portion of the total premium the state pays to provide employees with coverage.

Summary of Benefits and Coverage (SBC): A requirement of the Affordable Care Act, the SBC is a concise four-page document that details simple and consistent information about health plan benefits and coverage. It will help you to understand the basics of your coverage and allow you to compare any different coverage options you may have. It summarizes the key features of the plan, such as covered benefits, cost-sharing provisions, and limitations and exceptions. All insurance companies and group health plans must use the same standard SBC form. The SBC also contains a link to the required Uniform Glossary, which provides definitions of many commonly used health coverage and medical terms. To learn more, visit das.ohio.gov/benefits. The SBC is listed along the right navigation pane under the Publications and Notices section.

Third-Party Administrator (TPA): An organization or company that processes claims and other aspects of employee benefits plans on behalf of an employer.

Total Premium: The combination of the employee contribution and the state contribution.

Union-represented Employee: Also known as a Bargaining Unit Employee, is represented by a labor union and covered by the terms of a collective bargaining agreement.

Well-Being Assessment: A confidential questionnaire that assesses your physical, emotional and social health and how your lifestyle habits affect your overall well-being.

Well-Being Plan: A personalized summary of your overall well-being that offers personalized steps and recommendations.

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myOhio.gov

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Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you are eligible for health coverage from your employer, your State may have a premium assistance program that can help pay for coverage. These States use funds from their Medicaid or CHIP programs to help people who are eligible for these programs, but also have access to health insurance through their employer. If you or your children are not eligible for Medicaid or CHIP, you will not be eligible for these premium assistance programs.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, you can contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, you can contact your State Medicaid or CHIP office or dial 1-877-KIDS NOW or www.insurekidsnow.gov to find out how to apply. If you qualify, you can ask the State if it has a program that might help you pay the premiums for an employer-sponsored plan.

Once it is determined that you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must permit you to enroll in your employer plan if you are not already enrolled. This is called a "special enrollment" opportunity, and you must request coverage within 60 days of being determined eligible for premium assistance. If you have questions about enrolling in your employer plan, you can contact the Department of Labor electronically at www.askebsa.dol.gov or by calling toll-free 1-866-444-EBSA (3272).

If you live in one of the following States, you may be eligible for assistance paying your employer health plan premiums. The following list of States is current as of January 31, 2013. You should contact your State for further information on eligibility –

ALABAMA – Medicaid	ALASKA – Medicaid
Website: *www.medicaid.alabama.gov* Phone: 1-855-692-5447	Website: *health.hss.state.ak.us/dpa/programs/medicaid* Phone (Outside of Anchorage): 1-888-318-8890 Phone (Anchorage): 907-269-6529
ARIZONA – CHIP	**COLORADO – Medicaid**
Website: *www.azahcccs.gov/applicants* Phone (Outside of Maricopa County): 1-877-764-5437 Phone (Maricopa County): 602-417-5437	Medicaid Website: *www.colorado.gov* Medicaid Phone (In state): 1-800-866-3513 Medicaid Phone (Out of state): 1-800-221-3943
FLORIDA – Medicaid	**GEORGIA – Medicaid**
Website: *www.flMedicaidplrecovery.com* Phone: 1-877-357-3268	Website: *dch.georgia.gov* Click on Programs, then Medicaid, then Health Insurance Premium Payment (HIPP) Phone: 1-800-869-1150
IDAHO – Medicaid and CHIP	**INDIANA – Medicaid**
Medicaid Website: *accesstohealthinsurance.idaho.gov* Medicaid Phone: 1-800-926-2588 CHIP Website: www.medicaid.idaho.gov CHIP Phone: 1-800-926-2588	Website: *www.in.gov/fssa* Phone: 1-800-889-9949
IOWA – Medicaid	**KANSAS – Medicaid**
Website: *www.dhs.state.ia.us/hipp* Phone: 1-888-346-9562	Website: *www.khpa.ks.gov/hcf* Phone: 1-800-792-4884

KENTUCKY – Medicaid	LOUISIANA – Medicaid
Website: *chfs.ky.gov/dms/default.htm* Phone: 1-800-635-2570	Website: *www.lahipp.dhh.louisiana.gov* Phone: 1-888-695-2447
MAINE – Medicaid	**MASSACHUSETTS – Medicaid and CHIP**
Website: *www.maine.gov/dhhs/OIAS/public-assistance/index.html* Phone: 1-800-977-6740 TTY 1-800-977-6741	Medicaid & CHIP Website: *www.mass.gov/MassHealth* Medicaid & CHIP Phone: 1-800-462-1120
MINNESOTA – Medicaid	**MISSOURI – Medicaid and CHIP**
Website: *www.dhs.state.mn.us* Click on Health Care, then Medical Assistance Phone: 800-657-3629	Website: *www.dss.mo.gov/mhdparticipants/pages/hipp.htm* Phone: 573-751-2005
NEW JERSEY – Medicaid and CHIP	**NEW YORK – Medicaid**
Medicaid Website: *www.state.nj.us/humanservices/dmahs/clients/medicaid* Medicaid Phone: 609-631-2392 CHIP Website: *http://www.njfamilycare.org/index.html* CHIP Phone: 1-800-701-0710	Website: *www.nyhealth.gov/health_care/medicaid* Phone: 1-800-541-2831
NORTH CAROLINA – Medicaid and CHIP	**NORTH DAKOTA – Medicaid**
Website: *www.ncdhhs.gov/dma* Phone: 919-855-4100	Website: *http://www.nd.gov/dhs/services/medicalserv/medicaid* Phone: 1-800-755-2604
NORTH DAKOTA – Medicaid	**OKLAHOMA – Medicaid and CHIP**
Website: *www.nd.gov/dhs/services/medicalserv/medicaid* Phone: 1-800-755-2604	Website: *www.insureoklahoma.org* Phone: 1-888-365-3742
OREGON – Medicaid and CHIP	**PENNSYLVANIA – Medicaid**
Website: *www.oregonhealthykids.gov* Website: *www.hijossaludablesoregon.gov* Phone: 1-877-314-5678	Website: *www.dpw.state.pa.us/hipp* Phone: 1-800-692-7462
RHODE ISLAND – Medicaid	**SOUTH CAROLINA – Medicaid**
Website: *www.ohhs.ri.gov* Phone: 401-462-5300	Website: *www.scdhhs.gov* Phone: 1-888-549-0820
SOUTH DAKOTA – Medicaid	**TEXAS – Medicaid**
Website: *dss.sd.gov* Phone: 1-888-828-0059	Website: *gethipptexas.com* Phone: 1-800-440-0493
UTAH – Medicaid and CHIP	**VERMONT – Medicaid**
Website: *health.utah.gov/upp* Phone: 1-866-435-7414	Website: *www.greenmountaincare.org* Phone: 1-800-250-8427

VIRGINIA – Medicaid and CHIP	WASHINGTON – Medicaid
Medicaid Website: *www.dmas.virginia.gov/rcpHIPP.htm* Medicaid Phone: 1-800-432-5924 CHIP Website: *www.famis.org* CHIP Phone: 1-866-873-2647	Website: *hrsa.dshs.wa.gov/premiumpymt/Apply.shtm* Phone: 1-800-562-3022 ext. 15473
WEST VIRGINIA – Medicaid	**WISCONSIN – Medicaid**
Website: *dhhr.wv.govbms* Phone: 1-877-598-5820, HMS Third Party Liability	Website: *www.badgercareplus.org/pubs/p-10095.htm* Phone: 1-800-362-3002
WYOMING – Medicaid	
Website: *health.wyo.gov/healthcarefin/equalitycare* Phone: 307-777-7531	

To see if any more States have added a premium assistance program since January 31, 2013, or for more information on special enrollment rights, you can contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/ebsa
1-866-444-EBSA (3272)

OMB Control Number 1210-0137 (expires 09/30/2013)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Ext. 61565

State of Ohio Employee Health Plans
30 E. Broad St., 27th Floor, Columbus, Ohio 43215

Notice of Privacy Practices

Effective June 1, 2011

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

This Notice of Privacy Practices describes the privacy practices of the State of Ohio's self-funded medical plans, prescription drug plan, behavioral health plan, population health management plan, dental plans, vision plans, flexible spending account (but not dependent care flexible spending account) which are administered by the State of Ohio, Department of Administrative Services, Office of Benefits Administration Services (collectively "the Plan"). The Plan is required by the privacy regulations issued under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") to maintain the privacy of Protected Health Information (PHI), and to provide individuals with notice of the legal duties and privacy practices with respect to protected health information and to abide by the terms of the notice currently in effect.

Position on Privacy

The Plan is committed to maintaining the privacy of its enrolled persons. As part of your participation in the health plans, the Plan and its business partners (whom we use to administer and deliver health care services) receive health information through the operation and administration of the plans. PHI refers to any information, transmitted or maintained in any form or medium, which the Plan creates or receives that relates to your physical or mental health, the delivery of health care services to you or payment for health care services that identifies you or could be used to identify you. PHI and other Plan records are maintained in compliance with applicable State and federal laws.

If you have questions about this notice, please contact the Plan's HIPAA Privacy Contact listed below.

How the Plan May Use or Disclose Your Protected Health Information

The Plan may only use or disclose your medical information as described in this notice. Not every authorized use or disclosure in each category is listed, however all permitted uses and disclosures fall into one of these general categories.

1. **Uses and Disclosures of Your PHI For Treatment, Payment, and Health Care Operations**

   For Treatment. The Plan may make requests, uses, and disclosures of your PHI as necessary for treatment purposes. For example, the Plan may make disclosures to your health plan regarding eligibility, or make disclosures to health care professionals involved in your care.

   For Payment. The Plan may make requests, uses, and disclosures of your PHI as necessary for payment purposes. For example, the Plan may use information regarding your medical procedures and treatment so the third-party administrator can process and pay claims. We may also disclose your PHI for the payment purposes of a health care provider or a health plan.

   For Health Care Operations Purposes. The Plan may use and disclose your PHI as necessary for health care operations. For example, Health Care Operations include, but are not limited to, use and disclosures: by health plan of PHI to the Plan for administration of the health plans; for quality assessment of the plans through the distribution and analysis of satisfaction surveys; in connection with the performance of disease management functions; and for general administrative activities, including customer service, cost management, data management, communications, claims and operational audits, and legal services. In addition, a health plan may send you information based on your own health information to inform you of possible treatment options or alternatives that may be available to you. The Plan may also combine your health information with that of other enrolled persons to evaluate the coverage provided and the quality of care received.

2. **Other Uses and Disclosures of PHI for Which Your Authorization is Not Required**

In limited instances, the law allows the Plan to use and disclose your PHI without your authorization in the following situations:

A. As Required By Law. The Plan will use or disclose your PHI when required by federal, state or local law.

B. Family and Individuals Involved in Your Care. The Plan may release medical information about you to a family member or friend who is involved in your medical care. The Plan may request that your family members verify their identity and demonstrate they are acting on your behalf.

C. To Avert a Serious Threat to Health or Safety. The Plan may use and disclose medical information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public.

D. Public Health Activities. The Plan may disclose medical information about you for public health activities including activities related to preventing and controlling disease or, when required by law, to notify public authorities concerning cases of abuse or neglect.

E. Victims of Abuse, Neglect, or Domestic Violence. The Plan may disclose medical information to a government authority, including a social service or protective agency if the Plan reasonably believes you to be a victim of abuse, neglect, or domestic violence.

F. Health Oversight Activities. The Plan may disclose medical information to a health oversight agency if authorized by law in order to monitor the overall health care system, the conduct of government programs, and compliance with civil rights laws.

G. Lawsuits/Legal Disputes. The Plan may disclose medical information about you in the course of an administrative or judicial proceeding, such as in response to a subpoena, discovery request, warrant, or a lawful court order.

H. Law Enforcement Purposes. The Plan may release medical information to law enforcement officials for law enforcement

A. purposes including investigation of a crime or to identify or locate a suspect, fugitive, material witness or missing person.

B. Specialized Government Functions. The Plan may release medical information to authorized federal officials for the purposes of intelligence, counterintelligence, and other national security activities authorized by law.

C. Military. If you are a member of the armed forces, the Plan may release medical information about you as required by military command authorities.

D. Organ, Eye and Tissue Donation. If you are an organ donor, the Plan may release information to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.

E. Workers' Compensation. The Plan may release medical information about you for workers' compensation or similar programs that provide benefits for work-related injuries or illness.

F. Coroners, Medical Examiners, and Funeral Directors. The Plan may release medical information to a coroner or medical examiner to, for example, identify a deceased person or determine the cause of death. The Plan may also release medical information about patients to funeral directors as necessary to carry out their duties.

G. Business Associates. The State contracts with parties who provide necessary services for the operation of its plans. For example, the Plan is assisted in its operations by third party administrators. These persons who assist the Plan are called business associates. At times, the Plan may disclose PHI so they can provide services. The Plan will require that any business associates who receive PHI safeguard the privacy of that information.

H. Disclosure to You. The Plan may disclose your medical information to you.

3. Other Uses and Disclosures of PHI Requiring Your Written Authorization

In all situations other than those described previously, the Plan will ask for your written authorization before using or disclosing your PHI. If you have provided authorization, you may revoke it in writing at any time, unless the Plan has already disclosed the information.

4. Changes to Existing Laws

Certain provisions of Ohio law may impose greater restrictions on uses and/or disclosures of PHI, or otherwise be more stringent than federal rules protecting the privacy of PHI. If such provisions of Ohio law apply to a use or disclosure of PHI or under other circumstances described in this notice, the Plan must comply with those provisions.

Your Legal Rights

Federal privacy regulations provide you the following rights associated with your medical information:

Right to Request Restrictions. You have the right to request a restriction or limitation on the medical information the Plan uses or discloses about you for treatment, payment or health care operations. You also have the right to request a limit on the medical information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend. (For example, you could ask that the Plan not disclose or use information about a certain medical treatment you received.) The Plan is not required to agree to your request. To request restrictions on the use or disclosure of your PHI, you must make your request in writing to the Plan's HIPAA Privacy Contact listed below. In your request, you must explain (1) what PHI you want to limit; (2) whether you want to limit the Plan's use, disclosure, or both; and (3) to whom you want the limits to apply (for example, your spouse).

Right to Request Confidential Communications. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at a specific phone number or address. To request confidential communications, you must make your request in writing to the Plan's HIPAA Privacy Contact listed below. The Plan will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted. After the Plan receives your request, the information may be forwarded to your health plan. As a result, additional reasonable information may be required from you by your plan to process the request.

Right to Inspect and Copy Your Information. You have the right, in most cases, to inspect and copy medical information that may be used to make decisions about your care. To inspect and copy medical information that may be used to make decisions about you, you must submit your request in writing to the Plan's HIPAA Privacy Contact listed below. If you request a copy of the information, the Plan may charge a fee for the costs of copying, mailing, or other unusual supplies associated with your request. Under Ohio and federal law, the Plan may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to medical information, you may request that the denial be reviewed.

Right to Request an Amendment. If you feel that medical information about you is incorrect or incomplete, you may ask the Plan to amend the information. You have the right to request an amendment for as long as the information is kept. To request an amendment, your request must be made in writing and submitted the Plan's HIPAA Privacy Contact listed below. You must provide reasons that support your request. If the Plan denies your request for any reason under state or federal law, the Plan will permit you to submit a written statement of disagreement to be kept with your PHI. The Plan may reasonably limit the length of such statement of disagreement.

Right to an Accounting of Disclosures. You have the right to request an "accounting of disclosures." This is a list of certain disclosures the Plan has made of medical information about you. This accounting will not include many routine disclosures including, but not limited to, those made to you or pursuant to your authorization, those made for treatment, payment and operations purposes as discussed above, those made for national security and intelligence purposes, and those made to law enforcement in compliance with law.

To request this list or accounting of disclosures, you must submit your request in writing to the Plan's HIPAA Privacy Contact listed below. Your request must state the time period that may not be longer than six (6) years and may not include dates before April 14, 2003. Your request should indicate in what form you want the list (paper or electronic). The first list you request within a 12-month period will be free. For additional lists, the Plan may charge you for the costs of providing the list. The Plan will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

Right to a Paper Copy of this Notice. You have the right to a paper copy of this notice even if you have received it electronically. You may make your request to the Plan's HIPAA Privacy Contact listed below. The Plan will post a copy of the current notice at das.ohio.gov/benefits.

This Notice is Subject to Change

The Plan reserves the right to change the terms of this notice and its privacy practices at any time. If such a change is made, the new terms and policies will be effective for all of the information that the Plan has about you as well as any information it may hold about you in the future. If you want to ensure you have the latest version of this notice, you may contact the Plan's HIPAA Privacy Contact listed below.

Whom to Contact

If you believe your privacy rights have been violated, you may file a complaint with the Plan's HIPAA Privacy Contact listed below or with the Secretary of the Department of Health and Human Services.

To file a complaint with the Secretary of U.S. Department of Health and Human Services, contact the:

Office of Civil Rights
U.S. Department of Health and Human Services
233 N. Michigan Ave., Suite 240
Chicago, IL 60601

Complaints must be submitted in writing. You will not be penalized or retaliated against for filing a complaint.

Questions regarding this Notice may be directed to the Plan's HIPAA Privacy Contact:

Ohio Department of Administrative Services
HIPAA Privacy Contact
30 East Broad St., 27th Floor
Columbus, OH 43215
Phone Number: 614.466.6205
Email: gregory.pawlack@das.ohio.gov

Continuation Coverage Rights Under COBRA

Introduction

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 right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you when you would otherwise lose your group health coverage. It also can 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 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 must 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 of the following qualifying event:

- Your employment ends for any reason other than your gross misconduct.

If you are the spouse of an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because any of the following qualifying events occurs:

- Your spouse dies;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the plan because any of the following qualifying events happen:

- The parent-employee dies;
- 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, or the employee 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 your agency HR representative within 60 days after the qualifying event occurs.

How is COBRA Coverage Provided?

Once your agency HR representative 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, 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. For example, if a covered employee becomes entitled to Medicare eight months before the date on which his or her employment terminates, COBRA continuation coverage for the employee's 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 eight months). Otherwise, when the qualifying event is 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. Requests for disability extensions must be made in writing to the COBRA administrator, see Plan Contact Information below for address and phone number. You must include a copy of your most recent SSA disability approval letter. If your disability is not certified by the SSA, you do not qualify for the extension.

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 18 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, the Employee Retirement Income Security Act, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at: dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

Keep Your Plan Informed of Address Changes

To protect your family's rights, you should keep the plan administrator informed of any changes in the addresses of family members. You also should keep a copy, for your records, of any notices you send to the plan administrator.

Plan Contact Information:

UnitedHealthcare Benefits Services (UHCBS)
P.O. Box 221709
Louisville, KY 40252
866.747.0048

Women's Health and Cancer Rights Act of 1998: Notice of Rights

The Women's Health and Cancer Rights Act of 1998 (WHCRA) is a federal law that provides protections to patients who choose to have breast reconstruction in connection with a mastectomy. The terms of WHCRA provide:

A group health plan, and a health insurance issuer providing health insurance coverage in connection with a group health plan, that provides medical and surgical benefits with respect to a mastectomy shall provide, in a case of a participant or beneficiary who is receiving benefits in connection with a mastectomy and who elects breast reconstruction in connection with such mastectomy, coverage for:

1. all stages of reconstruction of the breast on which the mastectomy has been performed;
2. surgery and reconstruction of the other breast to produce a symmetrical appearance; and

1. prostheses and physical complications of all stages of mastectomy, including lymphedemas; in a manner determined in consultation with the attending physician and the patient. Such coverage may be subject to annual deductibles and coinsurance provisions as may be deemed appropriate and as are consistent with those established for other benefits under the plan or coverage.

If you have any questions about the State of Ohio's plans provisions relating to the Women's Health and Breast Cancer Rights Act of 1998, contact HR Customer Service at 614.466.8857 or 1.800.409.1205.

Newborns' and Mothers' Health Protection Act

Under the provisions of The Women's and Newborns' Act, group health plans and health insurance issuers generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a Caesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Patient Protection

The Ohio Med PPO generally allows the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. For information on how to select a primary care provider, and for a list of the participating primary care providers, please see the contact numbers for Medical Mutual and UnitedHealthcare below.

For children, you may designate a pediatrician as the primary care provider.

You do not need prior authorization from Medical Mutual or UnitedHealthcare or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a professional in our network who specializes in obstetrics or gynecology. The professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating professionals who specialize in obstetrics or gynecology, contact Medical Mutual at 1.800.822.1152 or UnitedHealthcare at 1.877.440.5977.

Creditable Coverage Disclosure:

Important Notice from the State of Ohio About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage, effective July 1, 2013, to June 30, 2014, with the State of Ohio and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not 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 about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about 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 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.

- The State of Ohio has determined that the prescription drug coverage offered by Catamaran 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 drug plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from Oct. 15 through Dec. 7. However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What happens to your current coverage if you decide to join a Medicare drug plan?

If you decide to join a Medicare drug plan, your current State Of Ohio coverage will not be affected. The State of Ohio has determined that the prescription drug coverage offered by Catamaran 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.

Go to: das.ohio.gov/prescriptiondrug for more details on your prescription benefits.

If you decide to join a Medicare Drug Plan and drop your current state medical coverage, be aware that you and your dependents will not be able to get this coverage back unless you experience a qualifying event or sign up during Open Enrollment.

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with the State of Ohio 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 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 percent of the Medicare base beneficiary premium per month for every month

that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19 percent higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following November to join.

For more information about this notice or your current subscription prescription drug coverage…

Contact the person listed below for further information at 1.800.409.1205.

NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through the State of Ohio changes. You also may request a copy of this notice at any time.

For more information about your options under Medicare prescription drug coverage…

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:
Visit: 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:
socialsecurity.gov or call them at 1.800.772.1213
(TTY 1.800.325.0778).

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).

July 1, 2013

State of Ohio
Ohio Department of Administrative Services
Benefits Administration Services
Prescription Drug Benefits Manager
30 East Broad, 27th Floor
Columbus, OH 43215
1.800.409.1205

Health and Other Benefits Contacts

ALL EMPLOYEES

Medical
Medical Mutual of Ohio
1.800.822.1152
medmutualstateohioemployee.com
Group Number: 228000

UnitedHealthcare
1.877.440.5977
welcometouhc.com/ohio
Group Number: 702097

Prescription Drug
Catamaran
1.866.854.8850
MyCatamaranRx.com
Rx Group #: STOH

Behavioral Health & Substance Abuse
United Behavioral Health
1.800.852.1091
liveandworkwell.com
Website Access Code: 00832

Employee Assistance Program
1.800.221.6327
www.odh.ohio.gov/eap/eap.aspx

Take Charge! Live Well!
Healthways
1.866.556.2288
ohio.gov/tclw
(click the **Healthways Website** button)

24-Hour Nurse Advice Line
Healthways
1.866.556.2288, Option 1

Flexible Spending Accounts and Commuter Choice
WageWorks
1.855.428.0446
wageworks.com

EXEMPT EMPLOYEES ONLY

Dental
Delta Dental of Ohio
1.800.524.0149
deltadentaloh.com
PPO Plan
Group Number: 9273-0001

Vision
Vision Service Plan (VSP)
1.800.877.7195
vsp.com
Group Number: 12022518

Life Insurance
Basic and Supplemental Life Insurance
Minnesota Life
1.866.293.6047
lifebenefits.com

UNION-REPRESENTED EMPLOYEES ONLY

Union Benefits Trust
614.508.2255
1.800.228.5088
benefitstrust.org

Dental
Delta Dental of Ohio
1.877.334.5008
Group Number: 1009

Vision
Vision Service Plan
1.800.877.7195
Group Number: 12022914

EyeMed Vision Care
1.866.723.0514
Group Number: 9674813

Life Insurance
Prudential Life Insurance
1.800.778.3827
Group Number: LG-01049

Work/Life Program
Working Solutions Program
1.800.358.8515
Group Number: 4718

Legal Services
Hyatt Legal Services
1.800.821.6400
Group Number: 4900010

Ohio Department of Administrative Services
HR Customer Service

614.466.8857 / 1.800.409.1205

HRCustomerService@das.ohio.gov
das.ohio.gov/benefits

TIP: When placing your calls, please ensure you have the documentation you might need during the call:

- Group Number
- Employee ID Number
- Explanation of Benefits if call is regarding claims.

SAVE THE DATES

2013

July
- New benefit year begins

October
- Flexible Spending Account Open Enrollment

November
- Great American Smokeout – Nov. 21

December
- Use your remaining Flexible Spending Account money by Dec. 31.

2014

January
- New Flexible Spending Account plan year begins Jan. 1

February
- National Wear Red Day – Feb. 7

March
- 2013 Flexible Spending Account claims deadline – March 31

June
- Benefit year ends June 30

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Department of Administrative Services