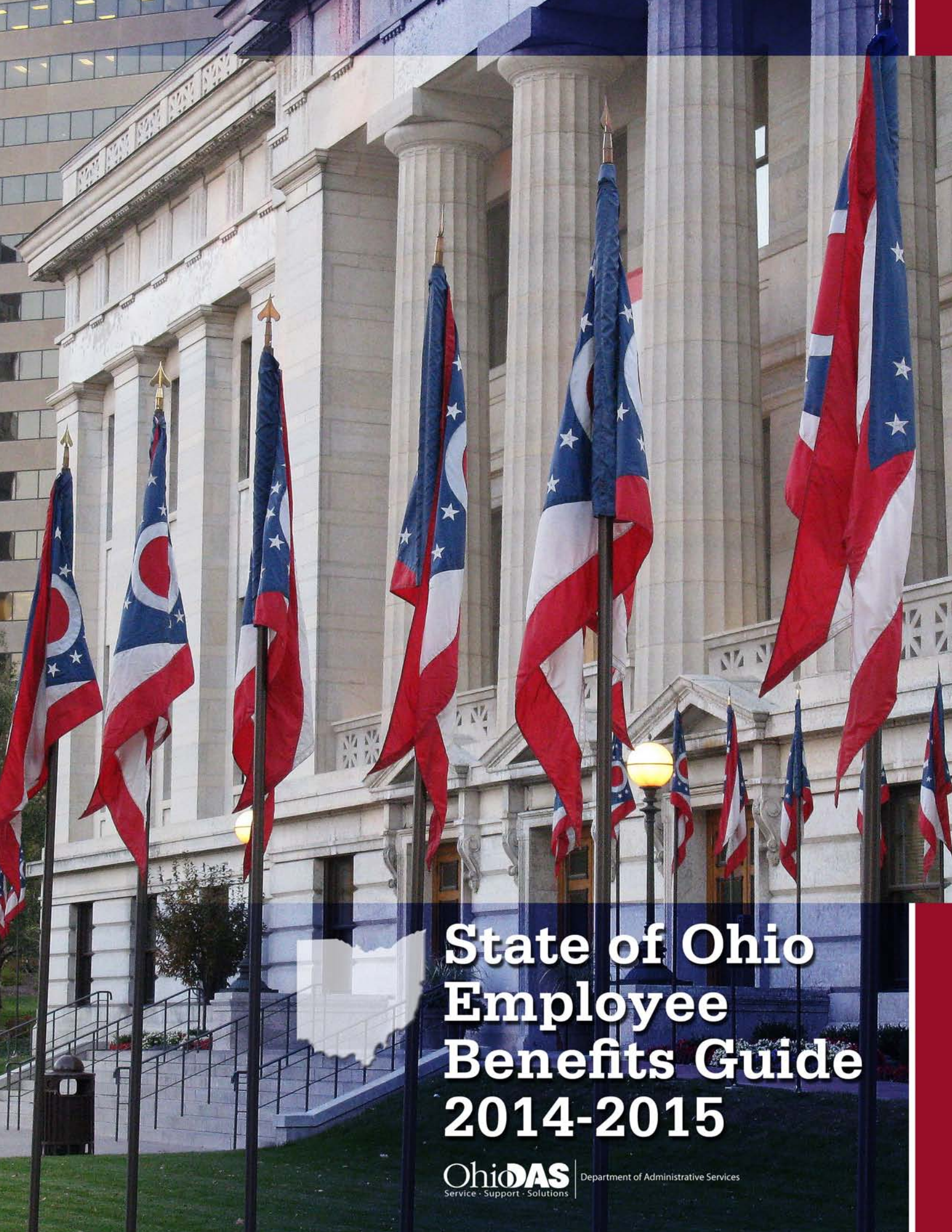

State of Ohio Employee Benefits Guide 2014-2015

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, 2014, and ends June 30, 2015.

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John R. Kasich
Governor
State of Ohio

Robert Blair
Director
Ohio Department of Administrative Services

The Joint Health Care Committee

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

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
Opportunities for Ohioans with Disabilities

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 Medicaid

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

Benefits Enrollment Instructions

Review your available benefits by carefully reading this 2014 – 2015 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, option 2, 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 State of Ohio User 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 State of Ohio User ID 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.

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.

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.

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.

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

Dependent Care Spending Account (Flexible Spending Account) Exempt and union-represented employees are eligible to enroll within 31 days of their date of hire. Accounts are effective the first day of the month following the receipt of the completed form.

Health Care Spending Account (Flexible Spending Account) Exempt and union-represented employees are eligible to enroll within 31 days of their date of hire or the successful completion of their initial probationary period, if applicable. The account will be effective the first day of the month following the receipt of the completed form.

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; however, dependent children ages 19 through 22 must be students.

3. Unmarried children incapable of self-care

Unmarried children who are incapable of self-support due to a qualifying developmental disability, 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 of the Ohio Med Preferred Provider Organization. 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.

4. 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:

- Child is unmarried, 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[1]
Children ages 23 - 25	Coverage available for eligible dependents[1]	No coverage available	No coverage available	Coverage available for eligible dependents[1]
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.

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.

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.

31 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 becomes ineligible for benefits coverage.

Medical

myohio.gov

IN the KNOW

Medical Mutual of Ohio
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
Optum Behavioral Solutions
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 Preferred Provider Organization (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.

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 31 days, 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 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 of this guide.

3-DIGIT ZIP CODE BREAKDOWN							
UNITEDHEALTHCARE							
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	

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 as inpatient; 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.
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 (review required). • 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.

[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.

[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 medical 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 and 15-18 months; 4-6 years
Haemophilus influenza b (Hib)	2, 4, 6 and 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 and 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 and 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. Please refer to: www.healthcare.gov/what-are-my-preventive-care-benefits for more information about preventive care services.

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;
- Track your health history;
- Learn about your prescription drugs;
- Take it all with you through the Catamaran mobile app.

Visit myCatamaranRx.com today. You will need your pharmacy member ID number on your Catamaran card to log in.

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

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, Briova, and must be for 30 days or less. 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 the **Specialty Drug Management Program** button.

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 in advance 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."

COPAYMENT COSTS

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

Behavioral Health

HELP AVAILABLE 24/7

Specialized behavioral health and substance abuse services are provided under a single program available to all employees and dependents enrolled in the state's medical plan. This program, administered by Optum 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:

- Alcohol and chemical dependency;
- Anger management;
- Anxiety;
- Compulsive disorders;
- Depression;
- Marital and family issues;
- Serious mental illness;
- Stress.

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

- 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 co-insurance 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 a network of participating providers and facilities. See the chart on the next page for further details.

EAP
OHIO EMPLOYEE
ASSISTANCE PROGRAM

SUPPORTING SERVICES

Also, the State of Ohio offers support services through the Ohio Employee Assistance Program (OEAP) for various behavioral health issues, which includes behavioral health referrals and consultations for employees and their family members. Other services include training, critical incident stress management and organizational transition. Visit ohio.gov/eap for more details.

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
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

MAKE WELLNESS YOUR PRIORITY

As we grow increasingly busy, leading a healthy lifestyle can be more challenging. We have to work harder to manage what we eat, how much we eat and how often we exercise.

In your effort to become a healthier you, *Take Charge! Live Well!* – the health and wellness program for state employees and spouses enrolled in the State of Ohio medical plan – is there for you with resources such as online trackers, videos and articles about health and wellness topics as well as a reward offered to encourage you in your efforts.

A healthier you starts out with completing the following:

- Your **Well-Being Assessment** and **Well-Being Plan**, via Well-Being Connect, the website of Healthways, the State of Ohio's wellness vendor;
- A **biometric screening**, either at your workplace or through your physician.

If you complete all three of the above between July 1 and Nov. 30, 2014, you will receive an additional $25 bonus for a total of $150.

Then choose your pathway – either the online pathway or the coaching pathway (phone calls from a personal health coach) – and you are on your way to a healthier lifestyle.

CHOOSE YOUR OWN REWARD

After completing an activity that merits a reward, you will be able to choose a reward card from many national brands.

When requesting your reward, you can request to receive your reward card after completing an activity, like your biometric screening or Well-Being Assessment, or you can allow your rewards to accumulate for a payout after completing multiple activities. This method puts you in control of when you request your gift card and the type of gift card you prefer.

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, 2014: **Earn another $25**

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

- Complete the Coaching Pathway; OR
- Complete the Online Pathway

Earn $200

COACHING PATHWAY

Prerequisite: Well-Being Assessment and biometric screening must be completed prior to earning a reward 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 online tools below to help you achieve your wellness goals. Each of the five online tools you choose must be completed 10 times.
   - Exercise and Fitness tracker
   - Steps tracker
   - Weight tracker
   - Food log
   - Servings 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 rewards and the *Take Charge! Live Well!* program, go to the *Take Charge! Live Well!* website at ohio.gov/tclw and click on the **Program Guide** button.

Diabetes Prevention Program

THE PROGRAM THAT HELPS PREVENT OR DELAY TYPE 2 DIABETES

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

WHAT IS PREDIABETES?

Prediabetes is a diagnosable condition where your blood sugar level is higher than normal, but is not high enough to be classified as type 2 diabetes. Often, there are no signs or symptoms. Without intervention, people with prediabetes have an increased risk of developing type 2 diabetes, heart disease and stroke in 10 years or less.

WHO IS ELIGIBLE FOR THE DIABETES PREVENTION PROGRAM?

The Diabetes Prevention Program, which offers either in-person or online sessions, is available to employees, spouses and dependents age 18 or older who are enrolled in State of Ohio medical insurance through UnitedHealthcare. The program is not currently offered to those enrolled in Medical Mutual of Ohio.

To qualify for participation in the program, an employee, spouse or dependent age 18 or older must meet one of the following criteria:

- Diagnosed with prediabetes by a nurse or doctor and have a body mass index (BMI) greater than 25;
- A testing result of fasting plasma glucoses of 100 to 125 with a BMI greater than 25;
- A testing result of Hemoglobin A1c of 5.7 to 6.4 with a BMI greater than 25.

NOT ME

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.

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

PROGRAM HIGHLIGHTS

IN-PERSON SESSIONS	ONLINE SESSIONS
16 lifestyle coaching group sessions	16 online sessions
Eight maintenance sessions	Eight maintenance sessions
Live coach	Coaching via live webinars and emails
Peers from your local community	Peers from throughout the U.S.
Scheduled sessions	24/7 access
Track goals and share results with team	Track progress of your team and other teams

DIABETES MANAGEMENT PROGRAM

All enrolled state employees and their dependents age 18 and older are eligible for free diabetic supplies and medication if they have had a Hemoglobin A1c test in the past 12 months.

TOBACCO CESSATION PROGRAM

All enrolled state employees and their dependents age 18 and older have access to QuitNet®, the industry's leading tobacco cessation program as well as unlimited online and phone coaching at no cost. Prescriptions and most over-the-counter products are available at no additional cost when actively working with a Healthways health coach. To enroll in health coaching, call 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[1]) 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 have completed an 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. If you do not enroll within 31 days of your anniversary date, you must wait until the next open enrollment period to obtain dental and/or vision care coverage.

Delta Dental Plan

Dental coverage is offered through the Delta Dental PPO plan, offered through Delta Dental of Ohio. You can go to any licensed dentist of your choice and receive benefits, but you typically will pay less when you go to an in-network dentist.

Your out-of-pocket expenses will vary depending on the participation status of your dentist. Your out-of-pocket costs are likely to be lower if you go to a dentist who participates in one of the Delta Dental networks. 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 pays the least for out-of-network dentists.

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 deltadental.com: Log in using your State of Ohio User ID number and date of birth.

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

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 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.

UNION BENEFITS TRUST

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

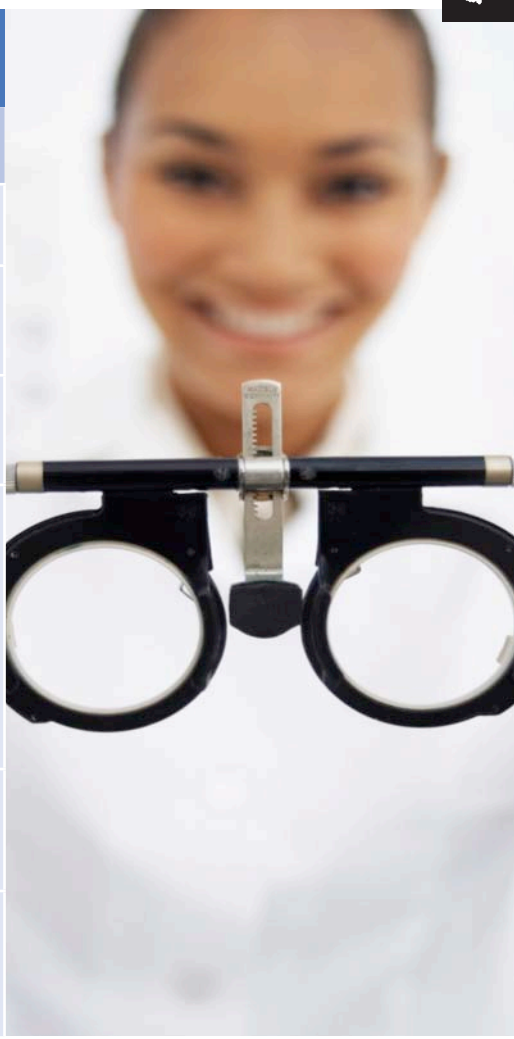
Deductible – $25 deductible per person total per benefit year. The deductible does not apply to diagnostic and preventive services, emergency palliative treatment, X-rays, periodontal maintenance (cleaning) and orthodontic services.

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.
FRAMES	Plan pays 100% up to $120 retail.	Plan pays maximum benefit of $18.
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
CONTACT LENSES Elective (Instead of Lenses & Frames)	Plan pays maximum of $125 plus standard eye exam.	
Medically Necessary	Plan pays 100% plus standard eye exam.	Plan pays maximum of $125 plus standard eye exam.



Financial Security

myOhio.gov

IN the KNOW

Basic and Supplemental Life Insurance
Minnesota Life
1.866.293.6047
lifebenefits.com

Flexible Spending Accounts and Commuter Choice
WageWorks
1.855.428.0446
wageworks.com

Your 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;
- Flexible spending accounts (health care spending account and dependent care spending account);
- Commuter Choice.

Union-represented employees may visit: benefitstrust.org or see Page 40 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 time 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. You may not waive or reduce your basic life coverage to avoid imputed income. See Page 22 for the imputed income rate chart.

EXEMPT SUPPLEMENTAL LIFE INSURANCE

Exempt employees are eligible to purchase supplemental life insurance coverage, which is provided through Minnesota Life. This coverage is at your own cost and can be purchased immediately upon employment or upon becoming an exempt employee with no waiting period. When you enroll in 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 40 for plan contact information.

For Yourself

You may enroll in Supplemental Life Insurance Coverage on your date of hire or upon becoming an exempt employee. 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 once it is processed by Minnesota Life. 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 forms section of the Benefits Administration website 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 40 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. You may designate one or several beneficiaries.

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

Employees have 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 his or her 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 is responsible for paying his or her 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

1. Obtain medical care promptly. If you wish to request salary continuation or occupational injury leave, you must use a provider approved by the Workplace Injury Labor Management Approved Provider Committee (WILMAPC). To locate an approved WILMAPC provider, 1) go to: das.ohio.gov/wilmapc and click on the **WILMAPC Approved Provider Panel** link to search for a provider; 2) or contact your human resources office.

   Failure to adhere to your agency accident 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.
2. Reporting: follow your agency's policy on reporting accidents and injuries.
3. Complete an Accident or Illness Report (ADM 4303), located at das.ohio.gov/healthcareforms.

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 and agency accident reporting guidelines are followed.
- Benefits are not to exceed 480 hours.
- This benefit is available to permanent full-time or permanent 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).
- Bargaining unit employees may appeal a denied salary continuation decision and should refer to the appeal procedure in their union contract.
- Appeals should be sent to the Office of Collective Bargaining of the Ohio Department of Administrative Services within 20 days of the denial.
- Exempt employees may appeal a denied salary continuation decision by completing the Salary Continuation and 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 salary continuation are included in your bi-weekly pay.

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 and agency accident reporting guidelines are followed.
- 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 Salary Continuation and 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 Workers' Compensation Claim

- File an Accident or Illness Report using the ADM 4303 form located at das.ohio.gov/healthcareforms.
- 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.

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.

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 filing status) into an account to pay for eligible child care, dependent care or eldercare expenses.

Enrollment Eligibility

Health Care Spending Account (HCSA)

To enroll in an HCSA, you must:

- Be a permanent part-time or permanent full-time employee who has successfully completed her or his initial probationary period and has sufficient pay to cover the election amount; and
- Enroll within 31 days of the hire date, if there is no probationary period; or
- Enroll within 31 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 HCSA. If both a husband and wife are state employees, both may participate in 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 31 days of the hire date.

Both a husband and wife, regardless if they are state employees, may participate in DCSA as separate individuals but cannot exceed the $5,000 IRS annual 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 qualifying 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 31 days of the qualifying event.

For more detailed information about Flexible Spending Accounts, visit: das.ohio.gov/flexiblespendingaccount.

IRS Forfeiture Rules

Federal regulations provide certain forfeiture rules. For example, 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 to purchase your public transportation fare passes (e.g., bus pass) and van pool passes, directly from your transportation provider.

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

The 2014 IRS monthly allowable dollar limit for transit is $130. When you enroll for the Commuter Choice transit benefit, the fare pass will be delivered directly to your home address.

The 2014 IRS monthly allowable dollar limit for parking is $250. 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 the Commuter Choice Parking and Transit Program is $4.60 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.

Affordable Care Act: The Patient Protection and Affordable Care Act, also known as the Affordable Care Act (ACA), is a set of federal health care reforms that have various impacts on health plans, including the State of Ohio health plan.

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 Share or 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 Share or 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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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, 2014. You should contact your State for further information on eligibility –

ALABAMA – Medicaid	ALASKA – Medicaid
Website: *http://www.medicaid.alabama.gov* Phone: 1-855-692-5447	Website: *http://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: *http://www.azahcccs.gov/applicants* Phone (Outside of Maricopa County): 1-877-764-5437 Phone (Maricopa County): 602-417-5437	Medicaid Website: *http://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: *https://www.flmedicaidtplrecovery.com/* Phone: 1-877-357-3268	Website: *http://dch.georgia.gov/* Click on Programs, then Medicaid, then Health Insurance Premium Payment (HIPP) Phone: 1-800-869-1150
IDAHO – Medicaid	**INDIANA – Medicaid**
Medicaid Website: *http://healthandwelfare.idaho.gov/Medical/Medicaid/PremiumAssistance/tabid/1510/Default.aspx* Medicaid Phone: 1-800-926-2588	Website: *http://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: *http://www.kdheks.gov/hcf/* Phone: 1-800-792-4884

KENTUCKY – Medicaid	LOUISIANA – Medicaid
Website: *http://chfs.ky.gov/dms/default.htm* Phone: 1-800-635-2570	Website: *http://www.lahipp.dhh.louisiana.gov* Phone: 1-888-695-2447
MAINE – Medicaid	**MASSACHUSETTS – Medicaid and CHIP**
Website: *http://www.maine.gov/dhhs/ofi/publicassistance/index.html* Phone: 1-800-977-6740 TTY 1-800-977-6741	Website: *http://www.mass.gov/MassHealth* Phone: 1-800-462-1120
MINNESOTA – Medicaid	**MISSOURI – Medicaid**
Website: *http://www.dhs.state.mn.us/* Click on Health Care, then Medical Assistance Phone: 1-800-657-3629	Website: *http://www.dss.mo.gov/mhd/participants/pages/hipp.htm* Phone: 573-751-2005
MONTANA – Medicaid	**NEBRASKA – Medicaid**
Website: *http://medicaidprovider.hhs.mt.gov/clientpages/clientindex.shtml* Phone: 1-800-694-3084	Website: *www.ACCESSNebraska.ne.gov* Phone: 1-800-383-4278
NEVADA – Medicaid	**NEW HAMPSHIRE – Medicaid**
Medicaid Website: *http://dwss.nv.gov/* Medicaid Phone: 1-800-992-0900	Website: *http://www.dhhs.nh.gov/oii/documents/hippapp.pdf* Phone: 603-271-5218
NEW JERSEY – Medicaid and CHIP	**NEW YORK – Medicaid**
Medicaid Website: *http://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: *http://www.nyhealth.gov/health_care/medicaid/* Phone: 1-800-541-2831
NORTH CAROLINA – Medicaid	**NORTH DAKOTA – Medicaid**
Website: *http://www.ncdhhs.gov/dma* Phone: 919-855-4100	Website: *http://www.nd.gov/dhs/services/medicalserv/medicaid/* Phone: 1-800-755-2604
OKLAHOMA – Medicaid and CHIP	**OREGON – Medicaid**
Website: *http://www.insureoklahoma.org* Phone: 1-888-365-3742	Website: *http://www.oregonhealthykids.gov* *http://www.hijossaludablesoregon.gov* Phone: 1-800-699-9075
PENNSYLVANIA – Medicaid	**RHODE ISLAND – Medicaid**
Website: *http://www.dpw.state.pa.us/hipp* Phone: 1-800-692-7462	Website: *www.ohhs.ri.gov* Phone: 401-462-5300
SOUTH CAROLINA – Medicaid	**SOUTH DAKOTA – Medicaid**
Website: *http://www.scdhhs.gov* Phone: 1-888-549-0820	*Website: http://dss.sd.gov* Phone: 1-888-828-0059

TEXAS – Medicaid	UTAH – Medicaid and CHIP
Website: *https://www.gethipptexas.com/* Phone: 1-800-440-0493	Website: *http://health.utah.gov/upp* Phone: 1-866-435-7414
VERMONT – Medicaid	**VIRGINIA – Medicaid and CHIP**
Website: *http://www.greenmountaincare.org/* Phone: 1-800-250-8427	Medicaid Website: *http://www.dmas.virginia.gov/rcp-HIPP.htm* Medicaid Phone: 1-800-432-5924 CHIP Website: http://www.famis.org/ CHIP Phone: 1-866-873-2647
WASHINGTON – Medicaid	**WEST VIRGINIA – Medicaid**
Website: *http://www.hca.wa.gov/medicaid/premiumpymt/pages/index.aspx* Phone: 1-800-562-3022 ext. 15473	Website: *www.dhhr.wv.gov/bms/* Phone: 1-877-598-5820, HMS Third Party Liability
WISCONSIN – Medicaid	**WYOMING – Medicaid**
Website: *http://www.badgercareplus.org/pubs/p-10095.htm* Phone: 1-800-362-3002	Website: *http://health.wyo.gov/healthcarefin/equalitycare* Phone: 307-777-7531

To see if any more States have added a premium assistance program since January 31, 2014, 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)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

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

NOTICE OF PRIVACY PRACTICES

Effective April 1, 2014

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

I. 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.

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

K. 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.

L. 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.

M. 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.

N. 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.

O. 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 to 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 below.

Right to Breach Notification. You have the right to notification if a breach of your unsecured PHI has occurred.

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, and will be posted at das.ohio.gov and may be provided by mail if required. 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 Plan, mail your written comments to the address below:
>
> To file a complaint with the Secretary of US Department of Health and Human Services, contact the Office of Civil Rights, US 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:

DAS -- HIPAA Privacy Contact
30 East Broad St., 27th Floor
Columbus, Ohio 43215
614.466.6205; email: gregory.pawlack@das.ohio.gov

NOTICE OF RIGHT TO ELECT COBRA CONTINUATION COVERAGE

WHAT IS COBRA CONTINUATION COVERAGE?

On April 7, 1986, a federal law was enacted (Public Law 99-272, Title X) requiring that most employers sponsoring group health plans offer employees and their families the opportunity for a temporary extension of health coverage (called "continuation coverage") at group rates in certain instances where coverage under the plan would otherwise end. This notice is intended to inform you, in a summary fashion, of your rights and obligations under the continuation coverage provisions of the law. You, your spouse and dependent children, if any, should all take the time to read the entire notice carefully.

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 either one of the following qualifying events happens:

- Your hours of employment are reduced, or
- 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 happens:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- 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 happens:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);

- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the plan as a "dependent child."

*If a covered child of the employee is enrolled in the plan pursuant to a qualified medical child support order (QMCSO) during the employee's period of employment, he or she is entitled to the same rights under COBRA as if he or she were the employee's dependent.

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 or reduction of hours of employment, death of the employee, or the employee's is becoming entitled to Medicare benefits (under Part A, Part B, or both), the employer must notify the Plan Administrator of the qualifying event.

YOU MUST GIVE NOTICE OF SOME QUALIFYING EVENTS

For the other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. You must provide this notice to your employer.

HOW IS COBRA COVERAGE PROVIDED?

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

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the employee, the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), your divorce or legal separation, or a dependent child's losing eligibility as a dependent child, COBRA continuation coverage lasts for up to a total of 36 months. When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA continuation coverage for his spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months). Otherwise, when the qualifying event is 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: The 18 months may be extended to 29 months if a qualified beneficiary is determined by the Social Security Administration to be disabled (for Social Security disability purposes) at any time during the first 60 days of COBRA coverage. This 11-month extension is available to all individuals who are qualified beneficiaries due to a termination or reduction in hours of employment.

To benefit from this extension, a qualified beneficiary must notify the Plan Administrator or designated Plan Service Provider of the disability determination on or before 60 days from the COBRA start date, and before the end of the original 18-month period. If you do not notify the Plan Administrator or the designated Plan Service Provider within the required period of time, you may lose your right to the extension.

The affected individual must also notify the Plan Administrator or designated Plan Service Provider within 30 days of any final disability determination that the individual is no longer disabled. Coverage will end on the first of the month, following at least 30 days after the date of the Social Security final disability determination letter.

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.

Your Election Rights: When the Plan Administrator or designated Plan Service Provider is notified that one of these events has happened, they will in turn notify you that you have the right to choose continuation coverage. Under the law, you have at least 60 days from the date you would lose coverage (because of one of the events described above) to inform the Plan Administrator or the designated Plan Service Provider that you want continuation coverage. If you do not choose continuation coverage in a timely manner, your group health insurance coverage will end.

Coverage Rights: If you choose continuation coverage, the Plan is required to give you coverage which, as of the time coverage is being provided, is identical to the coverage provided under the plan to similarly situated employees or family members. Each covered person 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.

Maximum Period of Coverage: The law requires that you be afforded the opportunity to maintain continuation coverage for 36 months unless you lost group health coverage because of a termination of employment (for reasons other than gross misconduct) or reduction in hours. In that case, the required continuation coverage period is 18 months. These 18 months may be extended for affected individuals to 36 months from termination of employment if other events (such as a death, divorce, legal separation, or Medicare entitlement) occur during that 18-month period. In no event will continuation coverage last beyond 36 months from the date of the event that originally made a qualified beneficiary eligible to elect coverage.

California State Residence: Under California law, you may be eligible for a State mandated extension of benefits after your federally mandated COBRA period expires. California State laws allow an extension of COBRA benefits to a total of 36 months from the date of your qualifying event to Qualified Beneficiaries who begin COBRA coverage on or after January 1, 2003. You will be notified of this extension at the conclusion of your original COBRA coverage.

Flexible Spending Account or Medical Reimbursement Account: If you are participating in the company's Flexible Spending Account or Medical Reimbursement Account at the time of your termination or reduction of hours, you may also have the right to continue participation under COBRA based on the following parameters:

1. You will be allowed to continue coverage for the remainder of the current plan year if you have a balance remaining in your account at the time of your termination or reduction in hours;
2. You will not be able to receive reimbursements in excess of your original election amount in the account; and
3. You make monthly payments in the same amount as your regular payroll deductions while you were an active employee.

Adding Dependents to COBRA Coverage: A child who is born to or adopted by the covered employee during a period of COBRA coverage will be eligible to become a qualified beneficiary. In accordance with the terms of the Plan and the requirements of federal law, these qualified beneficiaries can be added to COBRA coverage upon proper notification to the Plan Administrator or designated Plan Service Provider of the birth or adoption.

Expiration of COBRA Coverage: The law also provides that continuation coverage may be cut short for any of the following five reasons:

1. The company no longer provides group health coverage to any of its employees;
2. The premium for continuation coverage is not paid on time;
3. The qualified beneficiary becomes covered - after the date he or she elects COBRA coverage - under another group health plan that does not contain any exclusion or limitation with respect to any pre-existing condition he or she may have;
4. The qualified beneficiary becomes entitled to Medicare after the date he or she elects COBRA coverage;
5. The qualified beneficiary extends coverage for up to 29 months due to disability and there has been a final determination that the individual is no longer disabled.

Limits to Pre-Existing Conditions: The Health Insurance Portability and Accountability Act of 1996 (HIPAA) restricts the extent to which group health plans may impose pre-existing condition limitations. These rules are generally effective for plan years beginning after June 30, 1997. HIPAA coordinates COBRA's other coverage cut-off rule with these new limits as follow:

If you become covered by another group health plan and that plan contains a pre-existing condition limitation that affects you, your COBRA coverage cannot be terminated. However, if the other plan's pre-existing condition rule does not apply to you by reason of HIPAA's restrictions on pre-existing condition clauses, the Plan may terminate your COBRA coverage.

You do not have to show that you are insurable to choose continuation coverage. However, continuation coverage under COBRA is provided subject to your eligibility for coverage; the Plan Administrator reserves the right to terminate your COBRA coverage retroactively if you are determined to be ineligible.

Insurance Premiums: Under the law, you may have to pay all or part of the premium for your continuation coverage. You may also be required to pay a 2% administration fee above the cost of the premiums. If you are disabled, you may be required to pay 150% of the premium during the 11-month extension period.

Grace Period: There is a grace period of 30 days for payment of the regularly scheduled premium.

Conversion Coverage: At the end of the 18-month, 29-month or 36-month continuation coverage period, qualified beneficiaries may be allowed to enroll in an individual conversion health plan provided a conversion health plan is available to active employees. Please read your health plan benefits booklet or Summary Plan Description regarding any option for conversion coverage after the expiration of COBRA coverage. If there is an option for conversion to an individual policy, follow the instructions provided to apply for the coverage, as it would be separate coverage, and would not simply be an extension of COBRA coverage.

IF YOU HAVE QUESTIONS

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

KEEP YOUR PLAN INFORMED OF ADDRESS CHANGES

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

Plan Contact Information:
COBRA Administrator
UnitedHealthcare Benefit Services (UHCBS)
P.O. Box 221709
Louisville, KY 40252
Phone: 1.866.747.0048

HEALTH INSURANCE PORTABILITY and ACCOUNTABILITY ACT (HIPAA) NOTICE

Federal law requires that group health plans allow certain employees and dependents special enrollment rights when they previously declined coverage and when they have new dependents. This law, the Health Insurance Portability and Accountability Act (HIPAA) also addresses the circumstances under which treatment for medical condition may be excluded from health plan coverage.

The information in this notice is intended to inform you, in a summary fashion, of your rights and obligations under these laws. You, your spouse and any dependents should all take the time to read the entire notice carefully.

Special Enrollments: If you decline enrollment for yourself or your dependents (including your spouse) because of having other health insurance coverage at the time of your eligibility to participate, you may enroll yourself or your dependents at a future point, provided that you request enrollment within 31 days after your other coverage ends. In addition, if you have a new dependent as a result of a marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within 31 days of such an event.

Please note that the company group health plan may have a pre-existing condition exclusion period. If you are a late applicant, the pre-existing condition limitation period may be up to 18 months. Check your benefit booklet or Summary Plan Description for details.

The Plan will not treat pregnancy as a pre-existing condition. Additionally, the Plan will not impose any pre-existing condition exclusion or limitation with regard to a child who, as of the last day of the 30-day period beginning with the date of birth, adoption, or placement for adoption, is covered under the Plan or has other creditable coverage.

Pre-Existing Conditions Limitations: Under HIPAA, the circumstances under which treatment for medical conditions may be excluded from health plan coverage are limited. Under the law, the length of a pre-existing condition or exclusion must be reduced by your prior health plan coverage. A "pre-existing condition" is defined as an illness, injury or condition which was diagnosed or for which medical advice, care or treatment was recommended or received within the six-month period prior to your enrollment date in the plan, or if the plan has a waiting period, prior to the first day of the waiting period.

Certificate of Creditable Coverage: You are entitled to a certificate from your employer, or former employer, that shows evidence of your prior health coverage. HIPAA requires an employer (who may designate a Plan Service Provider) to provide a certificate of creditable coverage to:

1. An individual who is entitled to elect COBRA continuation coverage;
2. An individual who loses coverage under a group health plan and who is not entitled to elect COBRA continuation coverage; and
3. An individual who has elected COBRA continuation coverage and such coverage ends for any reason.

Plans must also provide a certificate of creditable coverage upon request by a plan participant any time within 24 months of a loss of coverage.

Applying for Reduction of a Pre-Existing Condition Limitation: The pre-existing condition limitation period will be reduced by creditable coverage you have had under other qualifying health plans, provided you have not experienced a period of more than 63 continuous days during which you were not covered by a health plan, excluding any waiting period for plan coverage.

Qualifying group health plans include: 1) a group health plan; 2) individual health insurance; 3) Medicare; 4) Medicaid; 5) a military-sponsored health care program; 6) a medical care program of the Indian Health Service or of a tribal organization; 7) state health benefits risk pool; 8) a Federal employee health benefit program; 9) a public health plan; or 10) any health plan under section 5(e) of the Peace Corps Act.

Following your submission of a certificate of creditable coverage from your prior group health plan(s), the plan administrator (or the designated Plan Service Provider) will notify you of your pre-existing condition limitation period under the health plan. If you feel that the Plan Administrator erred in determining your period of creditable coverage under another group health plan in arriving at your pre-existing condition limitation period under this plan, you may appeal the determination by making a written request for review to the Plan Administrator within thirty (30) days of notice of your applicable pre-existing condition limitation period under the health plan. Please include with your appeal any evidence you feel should be considered by the Plan Administrator. The Plan Administrator will respond to your request for review within thirty (30) days of receipt of the appeal.

Obtaining Additional Information: If you need assistance in determining your rights under ERISA or HIPAA, you may contact your Plan Administrator or the U.S. Department of Labor by writing to the Chicago Regional office at 200 W. Adams Street, Suite 1600, Chicago, IL 60606, or by calling the Department at (312) 353-0900.

If you have any questions about this notice or the law, please contact your Plan Administrator at the number or location provided in your benefits booklet or Summary Plan Description.

Also, if you have changed marital status, or if you, your spouse or any other qualified dependents have changed addresses, please notify your local Human Resources Representative.

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
3. 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 (option 2) or 1.800.409.1205 (option 2).

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, 2014, to June 30, 2015, 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, 2014

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 (option 2)

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 Number: STOH

Behavioral Health and Substance Abuse
Optum Behavioral Solutions
1.800.852.1091
liveandworkwell.com
Website Access Code: 00832

Ohio Employee Assistance Program
1.800.221.6327
ohio.gov/eap

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
Delta Dental PPO
Group Number: 9273-0001

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

Life Insurance
Basic Life Insurance and Supplemental Life Insurance
Minnesota Life
1.866.293.6047
lifebenefits.com
Group Number: 34301

Initial logon credentials:
The initial user ID is "**OH**" plus your State of Ohio User ID. The initial password is your date of birth (MMDDYYYY) plus the last four digits of your Social Security Number.

UNION-REPRESENTED EMPLOYEES ONLY

Union Benefits Trust
614.508.2255
1.800.228.5088
benefitstrust.org

The websites of the Union Benefits Trust (UBT) vendors listed below can be accessed through the UBT website.

Dental
Delta Dental of Ohio
1.877.334.5008
Group Number: 1009

Vision
Vision Service Plan (VSP)
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

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

- Group Number
- State of Ohio User ID
- Explanation of Benefits if call is regarding a claim.

Ohio Department of Administrative Services
HR Customer Service
614.466.8857 (option 2) / 1.800.409.1205 (option 2)
HRCustomerService@das.ohio.gov
das.ohio.gov/benefits

Notes

Notes

SAVE THE DATES

2014

July
- New benefit year begins

October
- Flexible Spending Account Open Enrollment

November
- Great American Smokeout – Nov. 20

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

2015

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

February
- National Wear Red Day – Feb. 6

March
- 2014 Flexible Spending Account claims filing deadline – March 31

June
- Benefit year ends June 30

OhioDAS
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Department of Administrative Services